Hospital, Emergency, and Ambulance Services

Policy Number: MCS046.06
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Instructions for Use

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Related Policies
None

Coverage Guidelines

Hospital services (inpatient, outpatient, and observation services), emergency services, and ambulance services are covered when Medicare criteria are met.

Notes:

- Medicare does not cover emergency and urgent services provided outside of the United States. Some UnitedHealthcare Medicare Advantage (MA) plans may provide coverage for out-of-area emergent/urgent services rendered outside the United States. To determine if coverage is available, refer to the member's Evidence of Coverage for coverage information, which may include specific location or other applicable limitations.
- **UnitedHealth Passport Program**: Members participating in the UnitedHealth Passport Program are eligible to use the Passport benefit for non-emergency care (routine and preventive care) benefit when traveling within the UnitedHealth Passport service area. Contact the Customer Service Department to determine member's UnitedHealth Passport Program eligibility and the UnitedHealth Passport service area at 877-842-3210.

Inpatient Hospital Services

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 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 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; and
- The medical predictability of something adverse happening to the patient; and
- 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 documentation must clearly support the member's severity of illness and intensity of service to warrant the need for inpatient medical care

Concurrent review for inpatient admissions is based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission. [42 CFR § 412.3(d)(1) and (d)(3); 88 Fed. Reg. 22191 (Apr. 12, 2023)]

Hospital care that is custodial, rendered for reasons of convenience, or not required for the diagnosis or treatment of illness or injury is not appropriate for coverage or payment. Any extensive delays in the provision of medically necessary services are excluded from time counted towards the two-midnight benchmark. [*Medicare Program Integrity Manual, Ch. 6, § 6.5.2(A)(I)(B)*]

Note: If the physician or healthcare professional is uncertain if an inpatient admission is appropriate, then the physician or healthcare professional should consider placing the patient in observation.

Refer to the:
- Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A.
- National Coverage Determination (NCD) for Hospital and Skilled Nursing Facility Admission Diagnostic Procedures (70.5).
- Medicare Program Integrity Manual, Chapter 6, § 6.5.
- CMS Reviewing Hospital Claims for Admission Memo.
- CMS FAQs 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013.

(Accessed January 18, 2024)

Additional Considerations Supporting Inpatient Stay

- **Medicare's Inpatient-Only List**: Inpatient admissions where a medically necessary inpatient-only procedure is performed are generally appropriate for Medicare Part A payment regardless of expected or actual length of stay.
  - 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. For inpatient only, reference CMS Addendum E. - Final HCPCS Codes that Would Be Paid Only as Inpatient Procedures.
- **Case-by-Case Exceptions to the Two-Midnight Rule**: For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be payable under Medicare Part A on a case-by-case or individualized basis if the documentation supporting the severity of illness and intensity of service support medical necessity for inpatient services. [42 CFR 412.3(d)(3)]

Refer to the Medicare Program Integrity Manual Chapter 6, § 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment.

UnitedHealthcare uses the criteria below to supplement the general Medicare criteria regarding inpatient admissions at 42 CFR § 412.3(d)(1) and (3), *Chapter 1* of the *Medicare Benefit Policy Manual*, and *Chapter 6, § 6.5* of the *Medicare Program Integrity Manual*. UnitedHealthcare uses the criteria noted below in order to ensure consistency in reviewing the complex medical factors on which a physician may reasonably base their decision to admit a patient as an inpatient, including factors such as: patient history and comorbidities; the severity of signs and symptoms; the patient's current medical needs; and the risk of an adverse event. Use of this criteria to supplement the general provisions noted above provides clinical benefits that are highly

likely to outweigh any clinical harms, including from delayed or decreased access to items or services, because this additional criteria will provide greater consistency in determining when a patient's complex medical factors support inpatient admission.

Use of this criteria will also further CMS's goal of reducing inpatient admission errors.

- For more detailed elective inpatient hospital services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Elective Inpatient Services.
- For more detailed hospital services definitions/clinical criteria and guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Hospital Services: Observation and Inpatient.
- UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider.

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.

Note: The OPPS/ASC Payment System final rule fact sheet can be accessed at https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center.
(Accessed January 18, 2024)

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.

For more detailed observation care services definitions/clinical criteria and guideline, refer to the UnitedHealthcare Commercial Medical Policy titled Hospital Services: Observation and Inpatient.

Notes:
- 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 January 18, 2024)

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 January 18, 2024)

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 January 18, 2024)

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, and/or
- 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* 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 January 18, 2024)

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 January 18, 2024)

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 January 18, 2024)
- **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.

Emergency and Urgently Needed Services

Emergency and urgently needed services are covered when criteria are met. For coverage guidelines, refer to the Medicare Managed Care Manual, Chapter 4, §20.2 – Definitions of Emergency and Urgently Needed Services.
(Accessed January 18, 2024)

Note: We note that an MA organization may choose to cover services outside the network at higher cost-sharing for non-emergency services obtained outside network providers' normal business hours (e.g., covering services at an urgent care center on weekends or holidays).

Post-Stabilization Care Services

Post-stabilization care services are covered when criteria are met. For coverage guidelines, refer to the Medicare Managed Care Manual, Chapter 4, §20.5.1 – Definition of Post - Stabilization.
(Accessed January 18, 2024)

Follow-Up Care

While it is preferred that follow-up care be provided through deemed or contracted providers, follow-up care will be covered as long as the care required continues to meet the definition of either emergency services or urgently needed services. Refer to the guidelines for Emergency and Urgently Needed Services above.

Ambulance Services (HCPCS Codes A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, and A0436)

Ambulance for emergency transportation, including ambulance services dispatched through 911 or its local equivalent, when either an emergency situation exists as defined above or other means of transportation would endanger the member's health, are covered.

For coverage guidelines, refer to the:

- Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services.
- NCD for Pronouncement of Death (70.4).
- Medicare Managed Care Manual, Chapter 4, §20.1 – Ambulance Services.

(Accessed January 18, 2024)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the table for Ambulance Services.

Note: Depending on the plan, some members have additional routine transportation benefit (not a Medicare covered benefit). Refer to the member's evidence of coverage or contact the customer service department to determine eligibility for this additional benefit.

Non-Covered Ambulance Services

Ambulance services that are not covered include, but are not limited to:

- Member's condition does not meet the Medicare criteria for ambulance transportation. Refer to the Coverage Criteria above.
- Transport of ambulance staff or other personnel when the member is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a member at another hospital). This applies to both ground and air ambulance transports. Refer to the Medicare Benefits Policy Manual, Chapter 10, § 10.2.5 – Transport of Persons Other Than the Beneficiary.
- Paramedic charges for BLS (basic life support) or ALS (advanced life support) when the member is not transported by the ambulance supplier (e.g., charges from a city fire department or an ambulance provider that responds to a call without transport).

Note: The ambulance benefit is a transportation based benefit, so if ambulance supplier does not transport the member, no service was provided. Refer to the Medicare Benefit Policy Manual, Chapter 10, §10.2.6 – Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports.

- Paramedic intercept (PI) services and emergency response system (EMS) non-paramedic services that are billed separately from the transporting ambulance provider are not covered except when all the requirements are met. For specific requirements, refer to the Medicare Benefits Policy Manual, Chapter 10, §30.1.1 – Ground Ambulance Services.
  Notes:
  - The State of New York meets the requirements for the paramedic intercept services benefit; refer to the Medicare Claims Processing Manual, Chapter 15, §20.1.4 – Components of the Ambulance Fee Schedule.
  - There are Medicare Administrative Contractors (MACs) that have determined some states in their jurisdictions meet the rural area requirements; refer to the Ambulance Services table.

(Accessed January 18, 2024)

Supporting Information

Ambulance Services
Accessed January 18, 2024

LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L34549 (A56468)	Ambulance Services	Part A and B MAC	Palmetto GBA	NC, SC, VA, WV, AL, GA, TN
A52917	Rural Air Ambulance Service Protocols	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY

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References

Centers for Disease Control and Prevention, Patient Safety: What You Can Do to Be a Safe Patient. Time in the hospital can put members at risk for a healthcare-associated infection (HAI), such as a blood, surgical site, or urinary tract infection.

Cristina ML, Spagnolo AM, Giribone L, Demartini A, Sartini M. Epidemiology and Prevention of Healthcare-Associated Infections in Geriatric Patients: A Narrative Review. Int J Environ Res Public Health. 2021 May 17;18(10):5333.

Emori TG, Gaynes RP. An overview of nosocomial infections, including the role of the microbiology laboratory. Clin Microbiol Rev. 1993;6(4):428–442. Hospitalized patients face a higher risk of infections.

Inouye SK, Westendorp RG, Saczynski JS. Delirium in elderly people. Lancet. 2014;383(9920):911–922. The authors propose the term 'hospital-associated complications of older people' (HAC-OP) to distinguish new geriatric syndromes related to hospitalization. Based on literature review and clinical experience, the authors focused on five syndromes (delirium, functional decline, hospital-acquired incontinence, falls, and pressure injuries) which are associated with poorer outcomes (e.g., long hospital stays, more post-acute facility discharge, poorer function and higher mortality) and are more common in older inpatients.

Loke HY, Kyaw WM, Chen MIC, Lim JW, Ang B, Chow A. Length of stay and odds of MRSA acquisition: a dose-response relationship? Epidemiol Infect. 2019 Jan;147:e223. doi: 10.1017/S0950268819001110. PMID: 31364542; PMCID: PMC6625199. A dose-response relationship between length of stay and odds of MRSA acquisition was observed, with a length of stay 3 weeks or more (Adj OR 11.78-57.36, all P < 0.001) being the single biggest predictor of MRSA acquisition.

Monegro AF, Muppidi V, Regunath H. Hospital-Acquired Infections. [Updated 2023 Feb 12]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK441857/. Accessed October 30, 2023.

National Library of Medicine, Epidemiology and Prevention of Healthcare-Associated Infections in Geriatric Patients: A Narrative Review – PMC (nih.gov). Elderly patients are identified as being in the high-risk group for the development of healthcare-associated infections (HAIs) due to the age-related decline of the immune system, known as immunosenescence.

National Library of Medicine, Hospital-Acquired Infections - StatPearls - NCBI Bookshelf (nih.gov). The risk factors for hospital acquired infections include immunosuppression, older age, length of stay in the hospital, multiple underlying comorbidities,

frequent visits to healthcare facilities, mechanical ventilatory support, recent invasive procedures, indwelling devices, and stay in an intensive care unit (ICU).

Olde Rikkert M, Rigaud A, van Hoeyweghen R, de Graaf J. Geriatric syndromes: medical misnomer or progress in geriatrics? Neth J Med. 2003;61(3):83–87. Hospitalization may lead to complications which are not specific to the presenting illness, often called geriatric syndromes. Geriatric syndromes are conditions with increased prevalence in older people, multifactorial etiology, shared risk factors, and negative impact on patient outcomes.

Quality Improvement Organization Manual, Chapter 4, §4110 – Admission/Discharge Review.

U.S. Department of Health and Human Services, Office of Inspector General, CMS Oversight of the Two-Midnight Rule for Inpatient Admissions (hhs.gov). To reduce inpatient admission errors, CMS implemented the Two-Midnight Rule.

Wang FD, Chen YY, Chen TL, Lin YT, Fung CP. Risk factors and mortality of nosocomial infections of methicillin-resistant Staphylococcus aureus in an intensive care unit. J Crit Care. 2011 Feb;26(1):82-8. Methicillin resistance is very common with S aureus infection. In the intensive care unit, use of invasive devices/procedures and length of stay were the most important risk factors for infection.

Policy History/Revision Information

Date	Summary of Changes
01/01/2024	**Coverage Guidelines** ***Ambulance Services (HCPCS Codes A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, and A0436)*** • Added list of applicable HCPCS codes to service heading **Supporting Information** • Archived previous policy version MCS046.05

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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.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. UnitedHealthcare utilizes the additional criteria noted above to supplement Medicare coverage guidelines in order to determine medical necessity consistently. The additional coverage criteria was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.