

Hospital, Emergency, and Ambulance Services

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[Instructions for Use](#)

Table of Contents	Page
Coverage Rationale	1
CMS Related Documents	6
References	7
Policy History/Revision Information	7
Instructions for Use	8

Related Medicare Advantage Medical Policy
<ul style="list-style-type: none"> Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital
Related Commercial Policies
<ul style="list-style-type: none"> Elective Inpatient Services Hospital Services: Observation and Inpatient

Coverage Rationale

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 medical necessity of the member's inpatient admission, as evidenced by 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)].

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 \(70.5\)](#)
- [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](#)

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)]

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 by helping ensure inpatient admissions are not incorrectly denied when medically appropriate for a particular patient nor incorrectly approved when not reasonable and necessary for a patient. The potential clinical harms of using this criteria may include inappropriately denying an inpatient admission when it is otherwise indicated, which could lead to potential medical complications by not being closely monitored in the hospital. The clinical benefits of using this criteria are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria helps ensure consideration of all factors on which a physician may reasonably base their decision, and therefore is unlikely to lead to circumstances where inpatient admissions are inappropriately denied. In addition, use of the criteria may decrease inappropriate denials by creating a consistent set of review criteria. Further, use of the criteria should limit the circumstances where patients are inappropriately admitted as inpatient, which itself provides benefits because it prevents unnecessary development of adverse events (e.g., falls, pressure ulcers, medication complications, venous thromboembolism). Additionally, unnecessary exposure to the hospital may decrease the risk for developing a hospital acquired infection. 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 guidelines, 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](#).
- As described in the commercial policies referenced above, 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>.

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>.

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](#).

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](#).

Long Term Care Hospitals (LTCH)

Refer to the Medicare Advantage Medical Policy titled [Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital](#).

Never Events

Neither Medicare nor UnitedHealthcare Medicare will reimburse for the following services:

- 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; refer to the [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 \(140.8\)](#).

Notes:

- The member is not responsible for coinsurance/copayment.
- Denial Notice Requirements:** For notification of non-coverage, refer to the [Parts C and D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).

- **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](#).

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](#).

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

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](#)

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.

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the [Medicare Coverage Database](#), if no NCD, LCD, or LCA is found, refer to the criteria as noted in the [Coverage Rationale](#) section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Ambulance Services				
N/A	N/A	A52917 Rural Air Ambulance Service Protocols	Part A and B MAC	Noridian

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	States/Territories
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers.	
**For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

CMS Benefit Policy Manual

- [Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A](#)
- [Medicare Benefit Policy Manual, Chapter 1, §130 – Religious Nonmedical Health Care Institution \(RNHCI\) Services](#)
- [Medicare Benefit Policy Manual, Chapter 6, §10.1 – Reasonable and Necessary Part A Hospital Inpatient Claim Denials](#)
- [Medicare Benefit Policy Manual, Chapter 6, §20 – Outpatient Hospital Services](#)
- [Medicare Benefit Policy Manual, Chapter 6, §20.6 - Outpatient Observation Services](#)

CMS Claims Processing Manual

- [Medicare Claims Processing Manual, Chapter 3, §150 – LTCHs PPS](#)
- [Medicare Claims Processing Manual, Chapter 4, §290 – Observation Services](#)
- [Medicare Claims Processing Manual, Chapter 4, §290.2.2 – Reporting Hours of Observation](#)

Medicare Program Integrity Manual

- [Medicare Program Integrity Manual, Chapter 6, § 6.5 – Medical Review of Hospital Claims for Part A Payment](#)

Medicare Managed Care Manual

- [Medicare Managed Care Manual, Chapter 4, §20.2 – Definitions of Emergency and Urgently Needed Services](#)
- [Medicare Managed Care Manual, Chapter 4, §20.5.1 – Definition of Post – Stabilization](#)

References

- Australian Commission on Safety and Quality in Healthcare. Hospital-acquired complications (HACs). Available from: <https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications>.
- 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/>.
- 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.
- San Jose-Saras D, Vicente-Guijarro J, Sousa P, Moreno-Nunez P, Aranaz-Andres JM; Health Outcomes Research Group of the Instituto Ramón y Cajal de Investigación Sanitaria (IRYCIS). Inappropriate hospital admission as a risk factor for the subsequent development of adverse events: a cross-sectional study. *BMC Med*. 2023 Aug 17;21(1):312.
- 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
12/01/2024	Template Update <ul style="list-style-type: none">Reformatted and reorganized policy; transferred content to new templateChanged policy type classification from “Coverage Summary” to “Medical Policy”Updated <i>Instructions for Use</i>

Date	Summary of Changes
	<p>Related Policies</p> <ul style="list-style-type: none"> Added reference link to the UnitedHealthcare Medicare Advantage Medical Policy titled <i>Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital</i> Added reference link to the UnitedHealthcare Commercial Medical Policy titled: <ul style="list-style-type: none"> <i>Elective Inpatient Services</i> <i>Hospital Services: Observation and Inpatient</i> <p>Coverage Rationale Inpatient Hospital Services Additional Considerations Supporting Inpatient Stay</p> <ul style="list-style-type: none"> Replaced language indicating “the clinical benefits of using [the criteria listed in the policy] are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria is unlikely to lead to circumstances where inpatient admissions are inappropriately denied” with “the clinical benefits of using [the criteria listed in the policy] are highly likely to outweigh any clinical harms, including from delayed or decreased access to services, because the criteria <i>helps ensure consideration of all factors on which a physician may reasonably base their decision, and therefore</i> is unlikely to lead to circumstances where inpatient admissions are inappropriately denied” <p>Long Term Care Hospitals (LTCH)</p> <ul style="list-style-type: none"> Replaced coverage guidelines with instruction to refer to the UnitedHealthcare Medicare Advantage Medical Policy titled <i>Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital</i> <p>Ambulance Services</p> <ul style="list-style-type: none"> Removed list of applicable HCPCS codes: A0430, A0431, A0435, and A0436 <p>Centers for Medicare and Medicaid Services (CMS) Related Documents</p> <ul style="list-style-type: none"> Updated list of documents available in the <i>Medicare Coverage Database</i> to reflect the most current information Added notation for the state of Virginia to indicate Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version MCS046.07

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference 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. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the [Administrative Guide](#).

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to

develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy 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.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT[®]), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT[®] or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate's requirements need to be followed.