Hospital Services: Observation and Inpatient (for Louisiana Only)

Policy Number: CS356LA.B
Effective Date: March 1, 2024

Instructions for Use

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Application

This Medical Policy only applies to the state of Louisiana.

Coverage Rationale

State Specific Criteria

Observation Procedure

Healthy Louisiana MCOs will reimburse up to 48 hours of medically necessary care for a member to be in an observational status. This time frame is for the physician to observe the member and to determine the need for further treatment, admission to an inpatient status, or for discharge. Observation and ancillary services do not require notification, precertification or authorization and will be covered up to 48 hours.

Hospitals should bill the entire outpatient encounter, including emergency department, observation, and any associated services on the same claim with the appropriate revenue codes, and all covered services are to be processed and paid separately.

Any observation service over 48 hours requires MCO authorization. For observation services beyond 48 hours that are not authorized, MCOs shall only deny the non-covered hours.

If a member is anticipated to be in observation status beyond 48 hours, the hospital must notify the MCO as soon as reasonably possible for potential authorization of an extension of hours. The MCO and provider shall work together to coordinate the provision of additional medical services prior to discharge of the member as needed.

Observation-to-Inpatient Procedure

Length of stay alone should not be the determining factor in plan denial of inpatient stay/downgrading to observation stay.

Medicaid members should not be automatically converted to inpatient status at the end of the 48 hours. Admission of a member cannot be denied solely on the basis of the length of time the member actually spends in the hospital.

All hospital facility charges on hospital day one are included in the inpatient stay and billed accordingly inclusive of emergency department/observation facility charges. **Note**: Professional charges should continue to be billed separately.

All observation status conversions to an inpatient hospital admission require notification to the MCO within one business day of the order to admit a member. Acceptable notifications include the use of MCO provider portals, admit discharge transfer notifications and other mediums through which plans accept clinical communications.

MCOs are prohibited from including any observation hours in the inpatient admission notification period.

The MCO will notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but within no more than one business day of making the initial determination. The MCO will subsequently provide written notification (i.e., via fax) to the provider within two business days of making the decision to approve or deny an authorization request.

Inpatient Hospital Services

Inpatient hospital care is defined as care needed for the treatment of an illness or injury which can only be provided safely and adequately in a hospital setting and includes those basic services that a hospital is expected to provide. The MCO shall not reimburse for care that can be provided in the home or for which the primary purpose is of a custodial or cosmetic nature.

The following requirements are applicable to hospital inpatient services. The MCO must ensure that its policies are in alignment with the requirements described below:

- Inpatient hospital services must be ordered by the following:
  - Attending physician, or other licensed and qualified health care provider;
  - An emergency room physician; or
  - Dentist (if the patient has an existing condition which must be monitored during the performance of the authorized dental procedure).
- Each day of an inpatient stay must be medically necessary.
- Physicians responsible for an enrollee's care at the hospital are responsible for deciding whether the enrollee should be admitted as an inpatient. Place of treatment must be based on medical necessity.
- The MCO shall require prior authorization for out-of-state non-emergency hospitalization unless the request for hospitalization is for a dual Medicare/Medicaid eligible enrollee. Additional service authorization requirements and exclusions are defined in the contract.

Non-State Specific Criteria

UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions, when applicable. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Click here to view the InterQual® criteria.

Definitions

Observation Time: The period beginning at the time the order is written to place a member in observation status or the time a member presents to the hospital with an order for observation, and ending with discharge of the member or an order for inpatient admission.

Observation Care: A well-defined set of specific, clinically appropriate services furnished while determining whether a member will require formal inpatient admission or be discharged from the hospital. Observation is for a minimum of one hour and up to 48 hours. The member must be in the care of a physician during the period of observation, as documented in the medical record by an observation order, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

References

Louisiana Department of Health, Louisiana Medicaid Managed Care Organization (MCO) Manual, Updated August 2, 2023. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf. Accessed August 9, 2023.

Policy History/Revision Information

Date	Summary of Changes
03/01/2024	**Definitions** • Removed definition of "Business Day" **Supporting Information** • Updated *References* section to reflect the most current information • Archived previous policy version CS356LA.A

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.