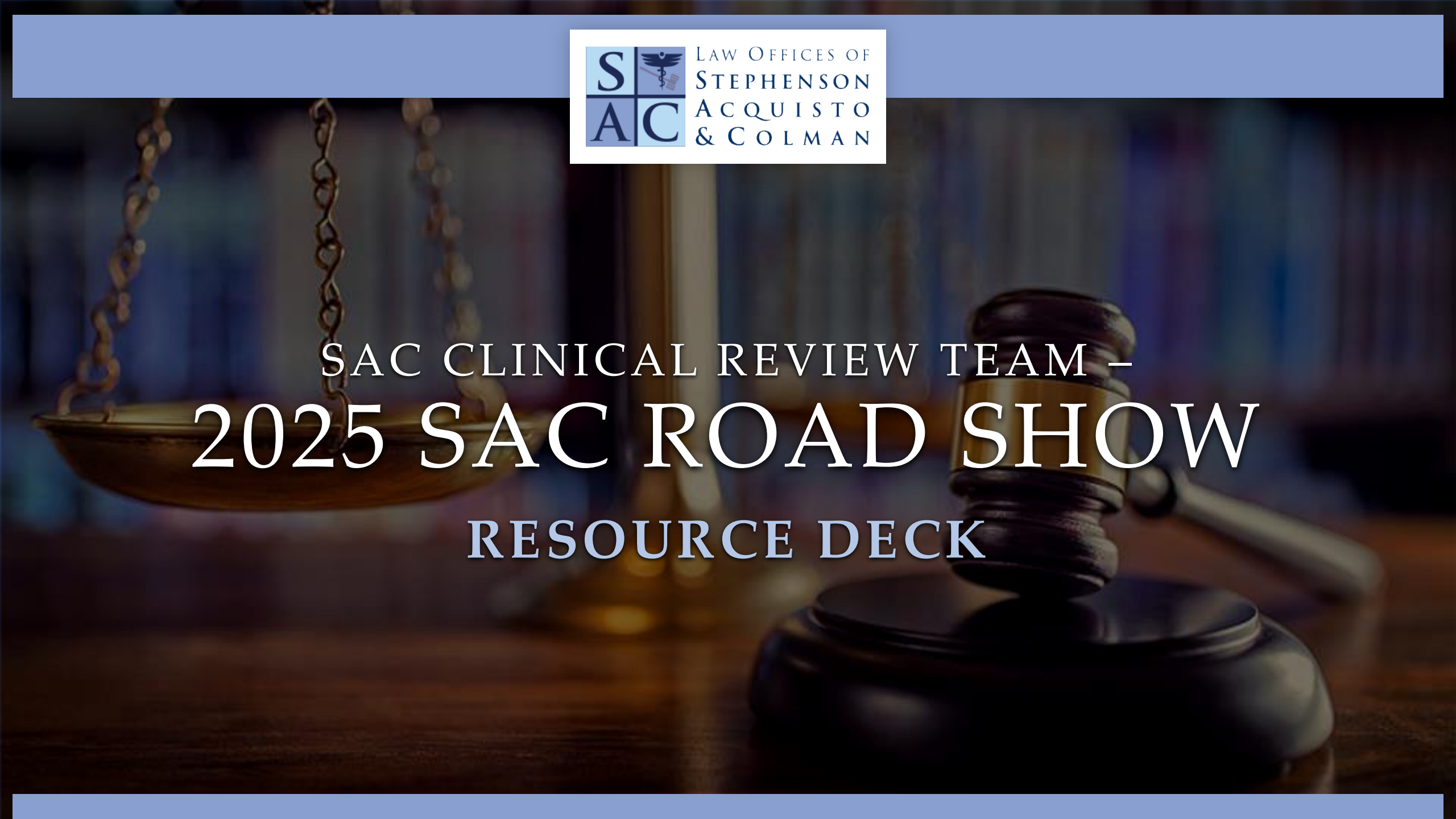

LAW OFFICES OF
STEPHENSON
ACQUISTO
& COLMAN

SAC CLINICAL REVIEW TEAM –

2025 SAC ROAD SHOW

RESOURCE DECK

RESOURCES: OUTPATIENT OBSERVATION

CMS Observation Services – Timeline

CMS started addressing Observation Services in the 2006 Outpatient Perspective Payment System (OPPS) annual update.

Since that time, it has been addressed many times in both the OPPS and the Inpatient Perspective Payment Systems (IPPS).

Example with the 2016 OPPS- CMS addressed previous ruling over two midnight rule. Benchmark vs Presumptive, Changes denials from MAC's to QIO's. Also reduced the look back period. RAC had already done their damage by now.

Most recently Observation services is also being addressed in the annual updates involving Medicare Advantage Plans 2024 final rule – CMS 4201-F

CMS addressed the Medicare Advantage (MA) Plans clarifying that MA plans must follow the Two-Midnight Rule and outlined specific guidelines for MA plans regarding short-stay exceptions and the use of the Inpatient Only List.

CMS Policy Statement

CMS Claims Processing Policy Manual

Pub 100-04 Chapter 4, Section 290: Observation Services

POLICY STATEMENT

Well defined, it is not! It confuses everyone!

290.1 - Observation Services Overview **(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09;** Implementation Date: 07- 06-09) Observation care is a well-defined set of specific, clinically appropriate **services**, which include ongoing **short term** treatment, assessment, and reassessment, that are furnished while a **decision** is being 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 make a **decision** 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 services. Observation services must also be reasonable and necessary to be covered by Medicare. In only **rare and exceptional** cases do reasonable and necessary outpatient observation services span more than 48 hours. 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 i less than 24 hours.**

Key words to consider:

1. **Services:** It's considered a "lane" of service, not a status determination of outpatient, it can only occur in an outpatient setting though
2. **Ordered** by an authorized provider
   1. State licensure law
   2. Hospital bylaws – have authority to ADMIT or order Outpatient services.
3. **Short Term:**
   1. 24 hours – typically
   2. Not more than 48 hours – rare cases> 48 hrs
4. **Decision** to inpatient or released from Emergency Department (ED)
   Commonly used when patient presented to **ED**

NOTE this does not include Operating Room (OR) Services

CMS Policy Statement

CMS Claims Processing Policy Manual

Pub 100-04 Chapter 4, Section 290.5.2.

Direct referral to Observation

POLICY STATEMENT

A Direct Referral to Observation Services is when a provider of the community refers a patient directly to a hospital for outpatient observation, bypassing the emergency department or outpatient clinic. This means the patient doesn't have to go through the usual process of presenting to a hospital's emergency room or clinic before receiving observation care.

Payment for direct referral for observation care will be made either separately as a hospital visit under APC 5013 (Level 3 Examinations & Related Services) or packaged into payment for comprehensive APC 8011 (Comprehensive Observation Services) or packaged into the payment for other separately payable services provided in the same Encounter.

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CMS Observation Services & The Two Midnight Rule

Benchmark vs Presumptive

When CMS first introduced the two-midnight rule, it was to be a "helpful" guidance in when a physician must choose the status of Inpatient (Part A billing) and Outpatient with Observation Services – Part B billing.

In the CY 2016 OPPS final rule, CMS:

Maintains the benchmark established by the original Two Midnight rule but permits greater flexibility for determining when an admission that does not meet the benchmark should nonetheless be payable under Part A on a case-by-case basis. Discusses a shift in enforcement of the Two Midnight Rule from MACs to Quality Improvement Organizations (QIOs) (discussed in more detail below).

Changes in Review: Short Inpatient Hospital Stays

For stays expected to last less than two midnights – CMS is adopting the following policies:

"For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.

CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.

No change for stays over the two-midnight benchmark:

For hospital stays that are expected to be two midnights or longer, our policy is unchanged; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice." – CMS

Note that the "crossing of two- midnights" clock starts when the episode of care was initiated.
This could be in ED, or in the field, or at an OSH.

CMS Policy

CMS Claims Processing Policy review on Observation

Pub 100-04 Chapter 4, Section 290.2.2

Reporting Hours of Observation

What to do

Observation Start Time:

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order.

Observation End Time:

Observation time ends when all medically necessary services related to observation care are completed.

For example:

Before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit).

The end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient.

Observation time may include medically necessary services and follow-up care provide after the time that the physician writes the discharge order, but before the patient is discharged.

Reported observation time **would not include the time** patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.

CMS Policy

Notice Requirement Related to Status Orders

Medicare Outpatient Observation Notice (MOON)

Enacted August 6, 2015, the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals and Critical Access Hospitals (CAH) to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status. The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release.

https://www.cms.gov/newsroom/fact-sheets/medicare-outpatient-observation-notice-moon

Medicare Change of Status Notice (MCSN)

MCSN to notify the patient of their expedited appeal rights. You must deliver the MCSN to all eligible patients as soon as possible, but no later than 4 hours prior to discharge. Eligible patients with

Part B must reach their 3rd day in the hospital before receiving the MCSN.

Effective November 14, 2024 – however the new appeal process was not in effect until February 2025.

Result of CMS 4204-F

The related regulations are available at 42 CFR 405.1210--405.1212.

Important Message (IM) &Detailed Notice of Discharge (DND)

Hospitals are required to deliver the Important Message from Medicare (IM), to all Medicare beneficiaries (Original Medicare beneficiaries and Medicare Advantage plan enrollees) who are hospital inpatients. The IM informs hospitalized inpatient beneficiaries of their hospital discharge appeal rights. A Detailed Notice of Discharge (DND) is given only if a beneficiary requests an appeal. The DND explains the specific reasons for the discharge.

More information can be found:

https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im

CMS Policy

Observation Services

The Physician Order

Know " Order" Requirements.

CMS addresses order requirement for Observation Services in CMS Claims Policy Manual, Chapter 4, section 290. Also make sure you are aware of CMS Medicare Benefit Policy Manual, Pub100-02, Chapter 1, section 10.2.1

"If admission order language used to specify inpatient or outpatient status is ambiguous, the best course of action would be to obtain and document clarification from the ordering practitioner before initial Medicare billing (ideally before the beneficiary is discharged). Under this policy, CMS will continue to treat orders that specify a typically outpatient or other limited service (e.g., admit "to ER," "to Observation," "to Recovery," "to Outpatient Surgery," "to Day Surgery," or "to Short Stay Surgery") as defining a non-inpatient service, and such orders will not be treated as meeting the inpatient admission requirement."

Additional Information for Outpatient and authorized provider with order writing privileges can be found at 42 CFR 482.54: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-D/section-482.54

Additional information regarding Inpatient order requirements, including physician requirement for order determination is found at CFR Part 424 Subpart B: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-B

CMS Policy

Observation Services

Section 290.5.1 – Billing and Payment for Observation Services

APC = Ambulatory payment classification. It is a Medicare payment system that classifies outpatient services into groups based on similar clinical characteristics and costs. APC to Outpatient claims is like DRG's to Inpatient claims.

All of the following requirements must be met in order for a hospital to receive an APC payment for an extended assessment and management composite APC:

1. Observation Time

a) Observation time must be documented in the medical record.

b) Hospital billing for observation services **begins** at the clock time documented in the patient's medical record, which coincides with the time that observation services are initiated in accordance with a physician's order for observation services.

c) A beneficiary's time receiving observation services (and hospital billing) **ends** when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d) The number of units reported with HCPCS code G0378 **must equal or exceed 8 hours.**

2. Additional Hospital Services

a) The claim for observation services must include one of the following services in addition to the reported observation services. The additional services listed below must have a line-item date of service on the same day or the day before the date reported for observation:

- A Type A or B **emergency department** visit (CPT codes 99284 or 99285 or
- HCPCS code G0384); or
- A **clinic visit** (HCPCS code G0463 beginning January 1, 2014; or
- **Critical care** (CPT code 99291- CPT code 99291 is used to report the critical care services provided to critically ill or injured patients for the first 30-74 minutes of care on a given day. It is a part of the broader range of CPT codes used for evaluating and managing critically ill patients. You can only use this code once per calendar date for the same patient by the same physician or group of the same specialty.); or
- **Direct referral** for observation care reported with HCPCS code G0379 (APC 0633) must be reported on the same date of service as the date reported for observation services.

b) **No procedure with a T status** indicator can be reported on the same day or day before observation care is provided.

(In Medicare billing, a "T" status indicator means that a code is reimbursable but is subject to a multiple procedure reduction if billed with other codes with the same status. Specifically, if multiple codes with the "T" status are billed together, the procedure with the highest APC payment rate receives full reimbursement, while the remaining "T" codes are reimbursed at 50% of their calculated rate.)

3. Physician Evaluation

a) The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by outpatient registration, discharge, and other appropriate progress notes that are **timed, written, and signed** by the physician.

b) The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

CMS Policy

CMS Claims Processing Policy review on Observation

Pub 100-04 Chapter 4, Section 290.2.2

Reporting Hours of Observation

What NOT to do

Observation services following outpatient surgery

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, 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.

Observation services during diagnostic or therapeutic services

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 payments for those diagnostic services.

Observation **services should not be billed concurrently** with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).

In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time.

For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation

CPT & HCPCS Codes

Both HCPCS and CPT codes are used for reporting observation services because they serve different purposes within the healthcare billing system.

CPT codes, primarily for physician services, are used to report the evaluation and management (E/M) services performed during observation, such as the initial observation service (99218-99220) or subsequent observation care.

HCPCS codes, on the other hand, are used to report hospital observation services, including the hourly observation service (G0378) and direct admission for observation (G0379)

CMS Policy

CMS Claims Processing Manual
Observation Services
Pub 100-04
Chapter 4, Section 290

Billing Code Reporting

Codes to look for on the UB

Section 290.2.1 – Revenue Codes

Hospitals are required to report observation charges under the following revenue codes:

Revenue Code Subcategory

- 0760 General Classification category
- 0762 Observation Room

Other ancillary services performed while the patient receives observation services are reported using appropriate revenue codes and HCPCS codes as applicable.

Place of Service (POS) Code

POS is typically 21

Section 290.5.1 – Billing and Payment for Observation Services

Hospitals are required to report HCPCS code G0378:

- These are measured in units of hours.
- The hours must equal or exceed 8 hours and should not exceed 48.
- Exceptions of going over 48, but not 72 are outlined.

In addition to HCPCS G0378; additional line items are required.

G0379 are used for billing direct referral [admissions] to observation.

CPT Codes

CPT 99221-99223 and 99231-99233 are used for initial and subsequent observation care services

CMS Policy UM and Billing Requirement

Condition Code 44

Condition Code 44 is a term often used in the Case Management, Utilization Review (clinical area)- however it is a billing term and a billing requirement when there is a specific type of status change that occurred as a result of the Utilization Review Committee requirement.

In billing, Condition Code 44 indicates that an inpatient admission has been retrospectively changed to an outpatient status. This means that a patient who was admitted to the hospital as an inpatient was later determined to have received care that could have been provided in an outpatient setting.

CMS Resources on Observation Services-

Areas in the CFR that supports decision making as it relates to Observation Services

CFR

Pertaining to Hospital and/or Authorized Provider for Outpatient/Observation

- 42 CFR § 412.3- Establishes Two Midnight Rule (2013)
- 42 CFR § 482.54- Conditions of Participation- Outpatient Services
- 42 CFR Part 419- Perspective Payment System for Hospital Outpatient Services.
- 42 CFR Part 419 Subpart I- Prior Authorization for certain Outpatient Services
- 42 CFR § 405.1210 Notifying eligible beneficiaries of appeal rights when a beneficiary is reclassified from an inpatient to an outpatient receiving observation services.
- 42 CFR § 405.1211 Expedited determination procedures when a beneficiary is reclassified from an inpatient to an outpatient Requirements. (Plan hère, referres to the Hospital plan of care).

Hospital Utilization Review Committee

- 42 CFR § 482.30
- https://www.ecfr.gov/current/title-42/section-482.30

Medicare Advantage Plans Utilization Review Committee

- 42 CFR § 422.137
- https://www.ecfr.gov/current/title-42/section-422.137

Pertinent Hospital Services - Impatient

- 42 CFR §412.3- Admissions- Part A
- 42 CFR § 409.10- Inpatient Hospital Services
- 42 CFR § 412.3- Requirements for admission orders

CMS Resources on Observation Services-

CMS Policy

CFR

- Chapter 1, section 10.2 Certification and Admission
- Chapter 6, section 20.2- Outpatient defined.
- Chapter 6, section 20.6 – Observation Services
  - A- Outpatient Observation Services Defined
  - B- Physician determines “reasonable and necessary”.

CFR

- Chapter 1, Section 150
- Chapter 1, section 50.2.2- addressing “T” procedure indicators and Observation
- Chapter 4, section 10.2.1 – Composite APC’s
- **Chapter 4, section 290- Observation Services**
- Chapter 30, section 450 - Expedited Determinations When a Beneficiary is Reclassified from an Inpatient to an Outpatient Receiving Observation Services.

CMS LCD- Outpatient Observation Bed/Room Services L34552

CMS Article- Billing and Coding: Outpatient Observation Bed/Room Services- A56673

CMS Observation Services & The Two Midnight Rule

The Two-Midnight Rule was created by CMS in the 2014 Hospital IPPS, which went into effect on October 1, 2013.

Because of the mass confusion and major complaints CMS received, CMS had to come out with "guidance" in both 2014 and 2015.

Here is a link to one of the 2015 guidance's:

https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0

Then CMS addressed it again in IPPS 2016 final rule.

There were also several "Change Requests (CR) and Transmittals going out.- still to this day it is not well defined, but CMS states that it is.

The physicians would say time and time again, " the care is the same, regardless of the status order! I am not here to worry about billing; I am here to take care of the patient. They were rightfully so annoyed, frustrated and always being interrupted in their day to "change the status order".

Comprehensive timeline: Two Midnight Rule Standards for Admission

RESOURCES: TRAUMA

Trauma Service Activation Fee

CMS believes that trauma activation is a one-time occurrence in **association with critical care services,** and therefore, CMS will only pay for one unit of G0390 per day.

- Trauma activation fees are assessed by many trauma centers to maintain the resources required for continuous trauma patient readiness.

- CMS have specific rules about billing for trauma activation.
- Commercial plans may or may not follow CMS guidelines.
  - Some plans follow the full reimbursement guidance
  - Some plans may omit parts of the requirement.
  - Some plans may have additional criteria requirements

Trauma Activation Fee is billable if:

STEP 1:

EMS notifies trauma center with patient information that includes supporting Trauma Criteria

STEP 2:

Trauma is Activated by the accepting trauma center

STEP 3:

Critical Services utilization + time

CMS-Trauma Activation Fee Requirements

Prehospital notification based on triage information from prehospital caregivers (i.e. EMS, transfer from outside hospital)

Meets the triage criteria who meet either local, state or American College of Surgeons field triage criteria

Meet the Critical Care criteria

Can be billed a trauma activation charge

Review of the UB-Provider Claim

The revenue code series 68x can be used only by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons.

Different subcategory revenue codes are reported by designated Level 1-4 hospital trauma centers.

CMS Claims Processing Manual, Pub 100-04, Chapter 25, §75.4

Document types considered in the clinical review process of trauma activation fee

CMS Resources

OPPS (Outpatient perspective payment system)- updated annually

Medicare Claims Processing Manual, Pub 100-04, Chapter 25, Section75.4

Medicare Claims Processing Manual, Pub 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 160. Critical Care Services

American College of Surgeon Trauma Criteria

State and County (CA) Pre- Hospital Trauma Criteria

In Network Provider Contract

Payer Provider Manual and/or Policy

Hospital Documentation

EMS/Ambulance Run Sheet

Transfer Summary – if transferred from another faculty

Pre-notification – when the hospital is notified about the trauma and agrees to accept

Trauma Run Sheet-Hospital
- Time of arrival – this may be found on the Hospital "Face Sheet" or emergency room documentation
- Course of actions during the trauma evaluation and treatment.
- Includes time stamps of who /what provider or health care team member involved in the care.

Emergency room notes/documentation
- Diagnostics
- Imaging
- Labs
- Orders

Trauma Surgeons or other specialty involved in the care documentation notes

Disposition
- Was the patient treated and released?
- Did the patient get transferred to another healthcare facility- if so, what type?
- Was the patient admitted as inpatient to the hospital

Emergency vs Critical Care

CMS: Critical Care time less than 30 minutes = Emergency level billing

As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

See Section 160.1 - Critical Care Services

Critical Care – Two level of Reimbursement With Trauma /Without Trauma

Beginning January 1, 2007, critical care services began receiving payment at two levels, depending on the presence or absence of trauma activation.

(1) Providers will receive one payment rate for critical care without trauma activation.

(2) Provider will receive additional payment when critical care is associated with trauma activation.

Medicare Claims Processing Manual, Pub 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS) Section 160. Critical Care Services

Critical Care Time Influences Trauma Activation Fee Reimbursement

Think about what happens during a trauma team activation:

1. The patient arrives with a high index of suspicion for critical injury.
2. The trauma team provides continuous, face-to-face care to determine whether the patient has any hidden injuries or needs immediate intervention.
3. The assessment, evaluation, treatment, interventions by the trauma team may meet the criteria for "critical care"
4. Or the assessment, evaluation, treatment, interventions by the trauma team may ultimately prove not to have a critical need, but from a billing perspective that is beside the point.

The time spent evaluating the patient is the consideration on whether critical care charges can be applied.

Critical Care Stabilization

Critical care codes are time-based.

So when does critical care time start and stop when it relates to Trauma?

Critical care time starts when the patient arrives

Critical care time ends when the patient has been cleared of any life-threatening injuries or moves to the next phase of care

EXAMPLE:

Say a patient involved in a motor vehicle crash arrives at the trauma center with a trauma team activation. The patient receives critical care before being stabilized.

If the patient is then waiting for admission to a non-ICU setting, critical care time will have ended at the point when one-on-one care was no longer necessary.

However, if the patient is being admitted to the ICU — and presumably still requires one-on-one care — the trauma team's critical care time will continue until ICU disposition.

Trauma – Evaluation then signs off

What happens when the trauma team activates but the patient is rapidly cleared?

According to CMS – the key issue is time

The thing to remember is that critical care time ends when it is determined the patient is no longer in jeopardy.

If critical care time is 30 minutes or greater, the trauma activation fee could be billed if all other criteria is met.

CMS: Critical Care with Trauma Activation

- Revenue Code – 68X
- G0390 – Trauma Activation
- CPT 99291 – Critical Care 30-74 minutes
- CPT 99292 – Each additional 30 minutes.

The hospital should bill one unit of code G0390, which describes trauma activation associated with hospital critical care services.- 99291/99292

Revenue code 68x must be reported on the same date of service.

The OCE will edit to ensure that G0390 appears with revenue code 68x on the same date of service and that only one unit of G0390 is billed.

CMS: Critical Care without Trauma Activation

Critical Care CPT 99291 – first 30-74 minutes

Critical Care CPT 99292 – each additional 30 minutes

As the CPT guidelines indicate, hospitals that provide less than 30 minutes of critical care should bill for a visit, typically an emergency department visit, at a level consistent with their own internal guidelines.

When critical care services are provided without trauma activation, the hospital may bill CPT code 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes (and 99292, if appropriate).

Under the OPPS, the time that can be reported as critical care is the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient.

If the physician and hospital staff or multiple hospital staff members are simultaneously engaged in this active face-to-face care, the time involved can only be counted once.

UHC Policy – For Example only – references CPT and CMS

UnitedHealthcare Community Plan

Reimbursement Policy
UB-04
Policy Number 2024F7025C

Outpatient Medical Visits and Trauma Activation Policy, Facility

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses 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. This reimbursement policy applies to all health care services billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the facility or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare

Trauma Activation

In alignment with CMS guidelines, in order to bill for trauma activation there must have been prehospital notification based on triage information from prehospital caregivers, who meet either local, state or American College of Surgeons field triage criteria, or are delivered by inter-hospital transfers, and are given the appropriate team response.

Trauma activation code G0390 can be submitted separately under revenue code 68X (068X) when provided on the same date of service as critical care service 99291. Revenue code 68X (068X) may only be used by trauma centers/hospitals as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons. Trauma activation is considered a one-time occurrence in association with critical care service. Therefore, only one unit of G0390 is reimbursable per date of service.

Trauma Activation will be considered for reimbursement only when the criteria for revenue code 068x, HCPCS code

G0390, and critical care code 99291 are met and are reported on the same date of service.

SEPTEMBER 1, 2025 CHANGE TO WHO WILL BE REVIEWING SHORT STAY REVIEWS

CMS Short Stay Reviews-

Notice to Hospitals

Beginning on September 1, 2025, the MACs will assume responsibility for conducting patient status reviews of facilities to determine the appropriateness of Part A payment for short stay inpatient hospital claims, which were previously conducted by the Beneficiary and Family Centered Care (BFCC) Quality Improvement Organization (QIO) (BFCC-QIO). While this change impacts where medical record requests will be sent and the contractor making claim review decisions, the policy for assessing short stay inpatient admissions remains unchanged.

Additional information is available on the CMS Medical Review and Education Webpage: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/hospital-patient-status-reviews

What's new?

2026

Annual Rule	Medicare Advantage Plan	IPPS+ LTAC	OPPS + ASC's
Rule and Rule Status (F/P)	4208-F	1833-P	1834-P
Release Date	April	April 11, 2025	July 15, 2025
Expected Date for Final Rule Release	FR was released in April 2025	August 1, 2025	November 1, 2025
Effective Date	January 1, 2026	October 1, 2025	January 1, 2026
Potential impacts to denial management.	Concurrent review is an organization determination subject to the requirements in part 422, subpart M, including notice and appeal rights.	Transforming Episode Accountability Model (TEAM)- Mandatory for selected hospitals- 5 surgery types	Wants to eliminate IPO list over next 3 years, wants to remove 285 procedures off the list in 2026

CMS 4208-F

RESOURCES

CMS 4208-F

422.138- Prior Auth.

https://www.ecfr.gov/current/title-42/section-422.138

Concurrent Review is subject to part 422, subpart M

The revision to § 422.616 we are finalizing in this rule specifically refers to approved inpatient admissions under § 412.3(d)(1) and (3). In the case of a prior approval for an inpatient admission per § 412.3(d)(2), plans will continue to be able to reopen those decisions on the basis of good cause for new and material evidence.

In this final rule, we [CMS] are modifying the MA reopening rules at § 422.616 to prohibit the reopening of a favorable inpatient hospital admission decision, including a decision subject to § 422.138(c), for good cause based on additional clinical information obtained after the initial decision.

CMS 4208-F

42 CFR 422.616(e)

NEW:

If the MA organization approved an inpatient hospital admission under the rules at § 412.3(d)(1) and (3) of this chapter, any additional clinical information obtained after the initial organization determination cannot be used as new and material evidence to establish good cause for reopening the determination.

CMS 4208

SSA 1852-

https://www.ssa.gov/OP_Home/ssact/title18/1852.htm

Medicare Advantage Enrollee's Appeal Rights – Coverage Determinations

Section 1852(g)(2) of the Act and § 422.580 provide MA enrollees with the right to request reconsideration of adverse organization determinations when there is a denial of coverage, in whole or in part.

CMS 4208

Revised:
§ 422.562(c)(2)

42 CFR 422.562

https://www.ecfr.gov/current/title-42/section-422.562

Claim has be adjudicated…

If a contract provider's request for payment has been adjudicated and the enrollee is determined to have no further liability to pay for the services furnished by the MA organization, the claim payment determination is not subject to the **appeal process in this subpart.**

CMS 4208

MA Discharge appeal: § 422.622

42 CFR 422.622

https://www.ecfr.gov/current/title-42/section-422.562

We [CMS] note that similar policies exist for other types of coverage denials. For example, after an MA organization determines that covered **inpatient care is no longer necessary,** the enrollee may file an expedited appeal of the discharge decision to the QIO.

If the QIO upholds the MA organization's decision, and the enrollee has left the hospital, in accordance with § 422.622(g)(2), the enrollee may continue their appeal to the ALJ, Departmental Appeals Board (DAB), and ultimately Federal court (if other conditions are met).

In these circumstances, enrollees are provided an explicit right to continue pursuing an appeal regardless of whether they have ceased receiving services or how long the appeal process takes.

CMS 4208-F

https://www.govinfo.gov/link/uscode/42/1395dd

Concurrent Review is subject to part 422, subpart M

Under our proposal, which we are finalizing, we clarify that concurrent review is an organization determination subject to the requirements in part 422, subpart M, including notice and appeal rights. As we further explain in section III.A.1. of this final rule, an MA organization only makes a determination on the enrollee's financial liability for services received, including any applicable cost-sharing amounts, when it adjudicates a claim for payment.

As we explained in the proposed rule, concurrent review decisions are coverage decisions, similar to pre-service decisions, and are not considered payment decisions. Therefore, an enrollee would only be liable for cost-sharing amounts, when applicable, after the MA organization makes a determination on such matters in response to a claim for payment. After an MA organization makes a payment determination on the enrollee's cost-sharing, in response to a claim for payment, the determination is binding and final upon the enrollee unless it is revised on appeal or reopening (see § 422.576).

We acknowledge that a pending appeal on the concurrent review denial could alter the plan's payment determination if the enrollee's concurrent review appeal is ultimately successful. However, we did not propose for enrollees to receive financial liability protection during the pendency of a concurrent review appeal.

CODE OF FEDERAL REGISTRY (CFR)

EMERGENCY AND POST STABILIZATION

Post Stabilization Coverage and Payment per CFR

Post Stabilization, with respect to an emergency medical condition:

Managed Care- 42 CFR-

42 CFR 438.114(e)

Coverage and payment: Post stabilization care services.

Post stabilization care services are covered and paid for in accordance with provisions set forth at § 422.113(c) of this chapter [Emergency Services]. In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States.

https://www.ecfr.gov/current/title-42/part-438/subpart-C#p-438.114(e)

THANK YOU!

ANY QUESTIONS?

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