Reimbursement Policy

Inpatient Hospital Admission and Length of Stay Reviews

REIMBURSEMENT POLICY NUMBER: 7

Effective Date: 6/1/2025

Last Review Date: 5/2025

Next Annual Review: 5/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims ☐ DMEPOS Suppliers

☒ **Non-Participating** Acute Hospital Facilities

Plan participating and contracted acute hospital facilities reimbursed on any of the following payment methodologies:

☒ DRG ☒ Modified DRG

☒ Percentage of billed charges/per diem

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

POLICY STATEMENT

Notes:

- This policy is based on guidelines set by the Centers for Medicare and Medicaid Services (CMS).
- This policy applies to any **inpatient hospital admission or length of stay review, regardless of whether it is performed pre-service, concurrently or post-service**.
- This policy does **not** apply to behavioral health inpatient admissions.
- This policy does **not** apply to skilled nursing facility (SNF) or inpatient rehabilitation facility (IRF) admissions.
- Separate reimbursement policies are available for facility supplies and services considered to be routine and bundled, inpatient ***re****admissions*, observation status reviews, transfers between hospitals, and preventable adverse events (See Cross References below).
- Facility contract language and payment methodology may vary.

General Process Overview

I. The Company hospital inpatient admission and length of stay review processes are as follows:

A. Any inpatient hospital case is eligible to be selected for either admission or length of stay review. These include, but are not limited to:

1. A short (spanning less than two-midnights) inpatient hospital stay.
2. An extended stay billed as observation (these are reviewed using the separate Company reimbursement policy for *Observation Status*).
3. High-dollar and medium-dollar claims for cost outlier reviews.
4. Concurrent authorizations.

B. For cases selected for review, all relevant medical records and clinical documentation will be requested.

C. The review:

1. Criteria used for this review process are noted in Criterion II.
2. A Registered Nurse (RN) will review the documentation to determine if the appropriate level of care was submitted for approval or reimbursement.
3. Cases are forwarded to a Company Medical Director for further review when the RN determines any of the following:

i. Inpatient admission was not appropriate.
ii. Inpatient criteria are not met.
iii. Continued hospitalization was unnecessary (or that outpatient care would have been equally effective).
iv. An unusual circumstance is identified, as determined by the Plan.

D. Notification is sent to the hospital provider with an explanation of the decision.

Coverage Consideration Criteria

II. **Inpatient hospital admissions** may be considered **appropriate and eligible for reimbursement** when **both** of the following (A. **and** B.) are met:

A. When applicable, all planned medical or surgical procedures must meet **both** (of the following (1. and 2.):

1. A covered member benefit; ***and***
2. Meet medically necessary coverage criteria, as determined by the use of relevant medical policies; ***and***

B. **One** of the following (1. or 2.) is met ***(please note specific line of business requirements)***:

1. The admission is for a surgical procedure found on one of the following Inpatient Only Lists:

   i. For **PEBB and Medicare Advantage plan members only**, the Centers for Medicare and Medicaid Services (CMS) Inpatient Only (IPO) List (see Policy Guidelines below) is applied.
   ii. For **all other plan members**, the InterQual® inpatient only list is applied.

2. If the planned medical or surgical procedure is a covered member benefit and meets any medical necessity criteria (if applicable), and is ***not*** on one of the above inpatient only lists, then **all** of the following (i.-v.) will be considered:

   i. InterQual® evidence-based criteria; ***and***
   ii. **One** of the following (a., b., or c.): ***and***

      a. The admitting physician expects the patient to require hospital care that crosses *at least* two-midnights based on factors documented in the medical record ***or***
      b. The admitting physician expects the patient to require care *less than* two midnights, but still determines that inpatient care is necessary based on complex medical factors documented in the medical record (examples include, but may not be limited to, the following situations [A-C]):

         A) Admission to an intermediate or intensive care unit level of care (including neonatal intensive care unit (NICU) *(**NOTE**: The admission to the intermediate or ICU/NICU must be considered medically necessary, as determined by InterQual® evidence-based criteria).*

B) Admission to acute hospital care at home. *(Subject to CMS initiative participation.)*

C) Transferred from another facility, with a medically necessary total length of stay greater than two days (i.e., the combined length of stay between the two facilities is greater than two days); ***or***

c. The admitting physician expects a hospital stay of at least two-midnights, but the hospital stay lasts *less than* two-midnights (examples of acceptable short-stay inpatient hospital admissions include, but may not be limited to, the following situations [A-D]).

A) Unexpected death during the admission.

B) Unexpected clinical improvement.

C) Left against medical advice from a medically necessary inpatient stay.

D) Election of hospice care in lieu of continued treatment in hospital.

iii. The independent medical judgment of the reviewing qualified health care professional; **and**

iv. The unique clinical circumstances of the member, such as their medical history and pre-existing conditions, co-morbidities, and current medical needs. Examples include, but may not be limited to, the following (a-d):

a. The severity of the signs and symptoms exhibited by the patient;

b. The medical predictability of something adverse happening to the patient;

c. The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the patient should be admitted; **and/or**

d. The availability of diagnostic procedures at the time when and at the location where the patient presents.

v. A specific order for inpatient admission by the admitting practitioner, furnished at or before the admission, is required. (See Policy Guidelines for more information about physician orders)

III. An inpatient hospital admission may be considered not eligible for reimbursement and are not medically necessary at an inpatient level of care when Criterion II. above is not met.

Length of Stay Reviews

IV. **All days of an inpatient hospital stay** may be considered **appropriate and eligible for reimbursement** when clinically appropriate inpatient level of care is provided during the entire course of the hospital stay as determined by Criterion II. above.

A. If a delayed discharge is identified (e.g., the member was medically stable and continued hospitalization was unnecessary, or that nursing home placement or discharge to home or institutional residence with home care was appropriate without posing a threat to the safety or health of the member, etc.), reimbursement may be reduced or denied.

1. **For Medicare Advantage members only,** the following may apply (i. **and** ii.)**:**

i. Days which the member was awaiting placement in a SNF **can** be included in calculating outlier status **IF** the patient was receiving a Medicare-covered SNF level of care services for the days in question and the record documents that Medicare SNF placement was being actively sought.

ii. Days which the member was awaiting placement in a SNF or other long-term care facility (i.e., assisted living facility) **cannot** be included in calculating outlier status **IF** the patient was receiving custodial care only.

POLICY GUIDELINES

DEFINITIONS

Custodial Care: "Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel." In determining whether a person is receiving custodial care, the level of care and medical supervision required and furnished are considered; however, diagnosis, type of condition, degree of functional limitation, or rehabilitation potential are **not** considered.[1]

Home or Residence[2]*:* A member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (e.g., assisted living facility, intermediate care facility for individuals with intellectual disabilities [ICF/IID], etc.). An *institution* would **not** be considered a member's home if it:

- Meets at least the basic requirement (see §1861(e)(1) of the Social Security Act (the Act)) in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment,

and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

- Meets at least the basic requirement (see §1819(a)(1) of the Act) in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Inpatient Admission: Admission to an inpatient level of care, vs. admission to an outpatient setting (e.g., observation, emergency room or ER, recovery, etc.)

Local Coverage Determination: LCD

Medicare Advantage Organization: MAO; Also referred to as a Medicare Advantage plan or MA plan.

National Coverage Determination: NCD

Non-Covered Long Term Care Facilities: Not all long-term care facilities are covered by Medicare. Examples of non-covered facilities include, but may not be limited to: Retirement home, assisted living facility (ALF), memory care facility, adult foster/family home (AFH), and custodial care facility.

APPROPRIATE LEVEL OF CARE (SETTING)

In order to be considered medically reasonable and necessary, Medicare expects services to be rendered at the appropriate level of care based on the individual's clinical needs. Medicare's reasonable and necessary criteria includes, but is not limited to, services being "furnished in a setting appropriate to the beneficiary's medical needs and condition," that the services are "ordered and furnished by qualified personnel," and that the service "meets, but does not exceed, the beneficiary's medical need."[3] In other words, lower-level services are expected to be rendered in a lower level setting.

PHYSICIAN ORDERS FOR INPATIENT ADMISSION

The Centers for Medicare and Medicaid Services (CMS) does **not** permit retroactive orders. Therefore, the physician order for inpatient admission must have been furnished at or before the admission.[4]

In addition, the order for inpatient admission must be clearly indicated in the medical record. The following orders will not be treated as meeting the inpatient admission order requirements:[4]

- Orders which are unclear.
- Orders which use codes or language not commonly understood by others outside of that hospital [e.g., "admit to 7W"].
- Orders that specify a typically outpatient or other limited service normally used to define a non-inpatient service or setting [e.g., admit "to ER," "to Observation," "to Recovery," "to Outpatient Surgery," "to Day Surgery," "to Short Stay Surgery," etc.].

Finally, according to CMS, the ordering or admitting practitioner is expected to take responsibility for the admission decision. This means the inpatient admission order cannot be a standing order. In

addition, while Medicare's rules do not *prohibit* use of a protocol or algorithm that is part of a protocol, only the ordering practitioner, or a resident or other practitioner acting on his or her behalf under section (B)(2)(a) can make and take responsibility for the inpatient admission decision. Thus, a decision to admit as an inpatient solely based on the hospital's use of such a tool does not in itself support inpatient level of care.[4]

LENGTH OF STAY REVIEWS

The "level of care" (i.e., inpatient, observation, etc.) does not determine total "length of stay," nor does the length of stay for a hospital admission determine level of care on its own merit.

Therefore, even if an inpatient hospital admission was appropriate, claims may still be subject to length-of-stay for cost outlier review. The Company may review to identify cases of potential delayed discharge (e.g., the member was medically stable and continued hospitalization was unnecessary, or nursing home placement or discharge to home with home care was appropriate without posing a threat to the safety or health of the member, etc.).[5]

Without accompanying medical conditions, factors that may cause the patient inconvenience in terms of time and money needed to care for the patient at home or for travel to a physician's office, or that may cause the patient to worry, do not justify a continued hospital stay or justify the approval of a higher-than necessary level of care. Note that "Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary." Therefore, extensive delays in the provision of medically necessary care are excluded from the 2-midnight benchmark calculation. However, while factors that may result in an inconvenience to a patient, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission, when such factors affect the member's health, these may be considered in determining whether an inpatient admission is appropriate.[5]

For Medicare Advantage members, in situations where the member is awaiting placement to a skilled nursing facility (SNF), but there is a lack of SNF beds or accommodations available, continued inpatient care may be necessary. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should state this specifically. Days which the member was awaiting placement in a SNF can be included in calculating outlier status if the patient was receiving a Medicare-covered SNF level of care for the days in question and the record documents that Medicare SNF placement was being sought.[6] It must be documented that genuine efforts were made to place the patient in a SNF within the normal placement area as soon as the bed becomes available. Coverage of these additional, "alternate placement" days in the hospital can continue until the earliest of the following events occurs:[7]

- A bed becomes available in a participating SNF,
- The member's care needs drop below SNF-level, ***or***
- The member has exhausted all of the available days of Part A inpatient hospital benefits in that benefit period.

As previously stated, lower-level services are expected to be rendered in a lower-level setting. When a member no longer needs acute hospital care, but still require skilled nursing services, the expectation is that they will be discharged from the acute hospital setting to the skilled nursing facility (SNF) setting in order to receive the lower level care services at the appropriate setting.[3] Thus, the purpose of this Medicare provision is to allow *lower* level services to be rendered at a *higher* level setting when necessary due to unusual circumstances, such as when no SNF is available to avoid a "level of care" or setting denial based on Medicare's reasonable and necessary requirements. This Medicare provision is **not** intended to allow coverage of custodial services. Custodial care services would not be covered in any setting, so they would not be intended to be covered in these situations either.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 4/11/2026, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital admissions and hospital stays:

- National Archives. Code of Federal Regulations 42 CFR § 412.3
- Centers for Medicare and Medicaid Services (CMS). *Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016*
- CMS. *Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A*
- CMS. *Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B*
- CMS. *Medicare Managed Care Manual, Chapter 17, Subchapter B, Payment Principles for Cost-Based HMO/CMPs, §70 - Provider Receiving Payment Under the Prospective Payment System PPS*
- CMS. *Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services*
- CMS. *Quality Improvement Organization Manual, Chapter 4 - Case Review*
- CMS. *Medicare General Information, Eligibility, and Entitlement, Chapter 4 – Physician Certification and Recertification of Services*
- CMS. *Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage*
- CMS. *Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services*
- CMS. *Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions*
- CMS. *Inpatient Only List 2023*
- CMS. *CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1772-FC)*
- CMS. *Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (CMS-4201-F)*
- CMS. *Acute Hospital Care at Home Data Release Fact Sheet*
- CMS. *CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge*
- CMS. *CMS Frequently Asked Questions (FAQ) for 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013*
- CMS. *CMS Manual System Pub 100-20 One-Time Notification. New Occurrence Span Code and Revenue Code for Acute Hospital Care at Home*
- CMS. *Acute Inpatient PPS*

The above reimbursement methodologies are consistent with the CMS regulatory references regarding inpatient hospital admissions and length of stay reviews.

The Medicare "Two-Midnight" Rule

This term has been used to describe two different things, but they are not the same thing. These are:

- "Two-midnight *presumption*," and
- "Two-midnight *benchmark*"

Two-Midnight Presumption

The "two-midnight **presumption**" is the presumption that all inpatient claims that cross two midnights are "presumed" to be appropriate for inpatient hospital payment and as such are not intended to be the focus of medical review absent other evidence that may indicate otherwise.

The two-midnight presumption is instruction given to Medicare post-payment audit and compliance contractors (e.g., Recovery Audit Contractors, or Quality Improvement Organizations [QIOs]) to help them in narrow the focus of their selection of claims for post-payment medical necessity reviews in Traditional Medicare. These reviews are then conducted to ensure that claims have been appropriately paid under Medicare rules.

The two-midnight presumption rule does **not** apply to Medicare Advantage (MA) or non-Medicare plans when deciding when and how to initiate the review of a particular inpatient stay.

Two-Midnight Benchmark

Inpatient care rather than outpatient care is required only if the patient's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. The two-midnight **benchmark** is part of the inpatient admission criteria outlined in 42 CFR. § 412.3, which states coverage must be provided, by furnishing, arranging for, or paying for an inpatient admission when, based on consideration of complex medical factors documented in the medical record, including whether or not the admitting physician expects the patient to require hospital care crosses two-midnights.

In other words, a stay expected to last two-midnights or longer serves as a "benchmark" in deciding whether or not the patient would appropriately be admitted as an inpatient or if they should remain at an outpatient (e.g., observation) status.

However, in order to be considered a "reasonable" expectation, this must be supported by the medical record documentation. In addition to using the two-midnight rule as a benchmark, additional factors to be considered when making the decision to admit include things such as:

- The severity of the signs and symptoms exhibited by the patient.

- The medical predictability of something adverse happening to the patient.
- 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.
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Preexisting medical problems or extenuating circumstances that make admission of the patient medically necessary would also be considered in this decision-making.

MA plans are required to consider these criteria, just as they would use NCDs, LCDs applicable to the plan's service area, and general coverage and benefit conditions found in Traditional Medicare laws. While proprietary screening instruments or utilization tools (e.g., InterQual®, MCG®, etc.) can also be used, the above list **MUST** be taken into account with every review and will supersede the proprietary criteria. Use of these tools alone – without consideration of or compliance with CMS coverage rules for inpatient hospital admissions is prohibited.

In all cases, medical directors must also apply clinical judgement when making medical necessity determinations.

Finally, factors that may result in an inconvenience to a patient or family do not, by themselves, justify inpatient admission. However, when such factors affect the patient's health, then these factors should be considered in determining whether inpatient hospitalization was appropriate.

The decision to admit by a physician because they reasonably expect the member to stay at least two midnights is not a guarantee of inpatient hospital payment. A MA plan **is able to** evaluate whether the admitting physician's expectation that the patient would require hospital care that crosses two-midnights was *reasonable* based on those complex medical factors documented in the medical record. Consistent with § 412.3, that evaluation should defer to the judgment of the physician ***as long as that judgment was reasonable based upon the complex medical factors documented in the medical record***.[5,8]

Inpatient admission criteria at § 412.3(d)(1) and (3) are both based on the expectation of the admitting physician at the time of admission. *Whether or not the admission **actually** crosses two midnights is **not** a factor in the inpatient admission criteria or in the level of care received.* A stay expected to last at least two-midnights would generally be considered appropriate for inpatient admission. However, an inpatient stay that does ***not*** last two-midnights should not automatically result in non-coverage of an inpatient admission either. CMS acknowledges that "unforeseen circumstances that result in a shorter stay than the physician's reasonable expectation may still result in a hospitalization that is appropriately considered inpatient… CMS anticipates that most of these situations will arise in the context of beneficiary death, transfer, or departure against medical advice. However, CMS does recognize that on occasion there may be situations in which the beneficiary improves much more rapidly than the physician's reasonable expectation. Such instances must be clearly documented and the initial expectation of a hospital stay spanning 2 or more midnights must have been reasonable in order for this circumstance to be an acceptable inpatient admission payable under Part A."[9]

Exceptions to the Two-Midnight Benchmark

Exceptions to the two-midnight benchmark do exist. These include:

- ***Medicare's Inpatient-Only List:*** Inpatient admissions where a medically necessary Inpatient-Only procedure is performed are generally appropriate for Part A payment (inpatient admission) regardless of expected or actual length of stay. Coverage of the inpatient admission for a procedure on the inpatient only list is considered to be "fully established under the applicable Medicare regulations and the MA plan must cover this type of inpatient admission without application of additional internal criteria."[8]

- ***Nationally-Identified Rare & Unusual Exceptions to the 2-Midnight Rule:*** If a general exception to the 2-midnight benchmark, as identified by CMS, is present within the medical record, the Medicare review contractor shall consider the inpatient admission to be appropriate for Part A payment so long as other requirements for Part A payment are met. CMS has identified "Mechanical Ventilation Initiated During Present Visit" as a national or general exception to the 2-midnight rule. This is because CMS believes newly initiated mechanical ventilation to be rarely provided in hospital stays less than 2 midnights, and to embody the same characteristics as those procedures included in Medicare's inpatient–only list. While CMS believes a physician will generally expect beneficiaries with newly initiated mechanical ventilation to require 2 or more midnights of hospital care, if the physician expects that the beneficiary will only require one midnight of hospital care, but still orders inpatient admission, Part A payment is nonetheless generally appropriate.

- ***Physician-Identified Case-by-Case Exceptions to the 2-Midnight Rule:*** For hospital stays that are expected to span less than 2 midnights, an inpatient admission may be appropriate on a case-by-case or individualized basis if the medical record supports the admitting physician/practitioner's judgment that the member required hospital care on an inpatient basis despite the lack of a 2-midnight expectation. Medicare contractors shall consider, when assessing the physician's decision, complex medical factors including, but not limited to:

    - The member's medical history and comorbidities;
    - The severity of signs and symptoms;
    - Current medical needs; ***and***
    - The risk of an adverse event.

CMS Inpatient Only List (IOL) Procedures

For the most current (2024) Addendum E published lists, see the Hospital Outpatient Prospective Payment Notices linked below.

- For **2024**, start from the 2024 Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment Period (NFRM) web page.
- For **2023**, start from the 2023 Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment (NFRM) web page.
- For **2022**, start from the 2022 Hospital Outpatient Prospective Payment Notice of Final Rulemaking with Comment Period (NFRM) web page.
- For **2021**, start from the 2021 Hospital Outpatient Prospective Payment Notice of Final Rulemaking with Comment Period (NFRM) web page.

From the applicable web page, click the link to the **"NFRM OPPS Addenda**" download file (you will need to accept "License agreement" when prompted). From the file, **Addendum EE** is the list of "HCPCS Codes That Would Be Paid Only as Inpatient Procedures." Once downloaded, open the "Addendum E" **excel** file. (The excel spreadsheet is preferred for viewing purposes over the notepad file, which is also included as an option.)

NOTE: The Company may use InterQual® Inpatient Only lists for any line of business, but for Medicare Advantage members the CMS IOL will always be used and will take precedent over any other IOL.

TWO-MIDNIGHT RULE SUMMARY

1. MA plans are **not** required to use the Medicare two-midnight **presumption** rule to determine which hospital claims to review. MAOs may decide on their own which claims to review. This means:
    a. MA plans are allowed to use prior authorization or concurrent case management review of inpatient admissions to determine whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission.
    b. MA medical necessity reviews may be conducted, at any time, such as before the service is provided (i.e., prior authorization), during (i.e., concurrent case review), or after the service is provided (i.e., post-service claim review). In each of these circumstances, MA organizations must comply with § 422.101(c).
2. MA plans **are** required to apply the two-midnight **benchmark** rule when reviewing the medical necessity of inpatient admissions.
    a. In order to be considered a "reasonable expectation," this must be supported by the medical record documentation.
    b. This includes consideration of general practices and evidence-based guidelines (e.g., InterQual®, as well as the members unique clinical history, severity of signs/symptoms, risk of adverse events, need and availability of diagnostic studies, and unusual circumstances.
    c. There are exceptions to the two-midnight rule as well, so whether or not the admission **actually** crossed two midnights is not a final deciding factor.

POST-SERVICE PRE-PAYMENT REVIEWS

Approval of Initial Admission vs. Length of Stay Reviews

According to CMS, if an MAO has approved a service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity. The plan may also not reopen such a decision for any reason except for good cause, reasons for which are detailed under 42 CFR § 405.986.[10,11]

When a member is first admitted to a hospital facility, the Plan reviews clinical documentation to assess the medical necessity and clinical appropriateness for an inpatient level of care. This decision is based on the clinical information known and available at that time. An approval of an inpatient admission means

that an inpatient level of care is medically reasonable and necessary for that member and that the **initial admission** has been approved.

However, this approval does **not** imply that an unlimited number of inpatient days have been approved. The remainder of the inpatient stay, including the total number of days the member is an inpatient at the facility, **must** continue to meet coverage criteria, including the requirement that all services must continue to be **both** medically reasonable **and** necessary. This means services must be furnished in a setting appropriate to the member's needs[3] for **all** days of the inpatient stay and that the level of services provided throughout the entirety of the stay meet, but do not exceed, the individual's medical needs.[3]

Clinical Benefits vs. Clinical Harms for Medicare Advantage Members

For Medicare Advantage members, the Plan uses the criteria above, as well as InterQual® criteria, to supplement the following general Medicare sources of criteria regarding inpatient admissions:

- 42 CFR § 412.3(d)(1) and (3), **and**
- Medicare Benefit Policy Manual, Chapter 1, **and**
- Medicare Program Integrity Manual, Chapter 6, §6.5.

Many complex medical factors may impact a decision to admit an individual to a facility as an inpatient. Factors include, but may not be limited to, these examples: patient history and comorbidities; the severity of signs and symptoms; the patient's current medical needs; and the risk of an adverse event.

Clinical *benefit*[8] of using these criteria to supplement the general Medicare provisions noted above includes ensuring inpatient admissions are:

- Not incorrectly denied when medically appropriate for a particular patient.
- Not incorrectly approved when not reasonable and necessary for an individual patient.

The potential clinical *harms*[8] of using these 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.

However, the clinical benefits of using these criteria are likely to outweigh clinical harms (e.g., delayed or decreased access to services). Use of these criteria is recommended for the following reasons[8]:

- Ensure consideration of all factors, including unique clinical circumstances of the individual member (i.e., their medical history, pre-existing conditions, co-morbidities, current medical needs, etc.) and independent physician judgment, and thus, unlikely to lead to inappropriately denied inpatient admissions.
- Decrease inappropriate denials by creating a consistent set of review criteria to avoid inappropriately admitting individuals to an inpatient setting, which can provide benefit by prevention of unnecessary development of adverse events (e.g., falls, pressure ulcers, medication complications, venous thromboembolism) or unnecessary exposure to hospital acquired infections.

- These criteria may further CMS's goal of reducing inpatient admission errors.

Acute Hospital Care at Home

"In response to challenges faced by hospitals because of the spread of COVID-19, CMS launched the Acute Hospital Care at Home (AHCAH) initiative in November 2020, which allowed certain Medicare-certified hospitals to treat patients with inpatient-level care at home."[12] With appropriate safeguards in place to protect patients so patient safety will not be compromised, CMS believed "that treatment for more than 60 different acute conditions, such as asthma, congestive heart failure, pneumonia and chronic obstructive pulmonary disease (COPD) care, can be treated appropriately and safely in home settings with proper monitoring and treatment protocols."[13]

It was anticipated that "patients may value the ability to spend time with family and caregivers at home without the visitation restrictions that exist in traditional hospital settings. Additionally, patients and their families not diagnosed with COVID-19 may prefer to receive care in their homes if local hospitals are seeing a larger number of patients with COVID-19."[13] CMS also notes it is the patient's choice to receive these services in the home or the traditional hospital setting and patients who do not wish to receive them in the home will not be required to.[13]

BILLING AND CODING GUIDELINES

Inpatient to Outpatient Rebilling

For Medicare lines of business or for providers who contract specifically with PHP to pay using CMS's Outpatient Prospective Payment System (OPPS)*, if the member has not yet been discharged, and it is determined that the services did not meet inpatient criteria, the facility can change the patient status from an inpatient to an outpatient, and bill accordingly.

If it is determined that a patient should not have been admitted as an inpatient, the facility should only submit medically reasonable and necessary Part B (outpatient) services and provide the correct Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes when available. Condition code W2 can be used to indicate that a claim is a Part B claim (including "A/B Rebilling" in the treatment authorization field is also recommended). For preadmission services in the 3-day payment window, a hospital may separately bill for services provided prior to an inpatient admission on an appropriate outpatient TOB 13x or 85x claim. This means the provider can only bill as follows:

- Medically necessary *inpatient* services that should have been provided on an outpatient basis can be billed on a Part B ***inpatient*** claim.
    - Since observation services are by Medicare definition "outpatient" services, they **cannot** be included on this claim.
- Medically necessary *outpatient* services ***leading up to*** the inpatient admission can be billed on a Part B ***outpatient*** claim.
- Services that were not performed at all cannot be submitted for reimbursement (e.g., changing an inpatient status claim to an observation status claim, even though observation services were not ordered nor were they rendered).

**For all other lines of business or facilities who do not fall in the above categories, the facility may change the bill type to observation post-discharge.*

Length of Stay/Outlier Payments

Reimbursement calculations may be affected if it is determined that an acute level of care was not required for some days of the stay, or that continued inpatient hospitalization was unnecessary and that outpatient care (e.g., SNF care) would have been equally effective in providing needed care without posing a threat to the safety or health of the patient. In addition, reimbursement calculations may also be impacted by the performance of non-covered procedures or services during a hospital admission.

For inpatient hospital services provided by a hospital paid under the Inpatient Prospective Payment System (IPPS) methodology, the facility is paid a predetermined amount for each inpatient stay based on the principal diagnosis or the inpatient stay. Under the IPPS, each case (hospital stay) is categorized into a diagnosis-related group (DRG) and each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. Each hospital stay is grouped by principal diagnosis into one of the many Diagnosis Related Groups (DRGs). An adjustment to a particular prospective payment may be needed, for example, where, upon medical review, the payment made was found to be improper or inaccurate.[14]

According to Medicare, "noncovered services generally excluded from coverage in the Medicare Program. This may result in denial of a part of the billed charges or in denial of the entire admission, depending upon circumstance."[4] Medicare also states that "[s]ervices 'related to' non-covered services… including… complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare."[4]

CROSS REFERENCES

- Facilty Routine Supplies and Services, RP43
- Inpatient Readmissions, RP54
- Observation Status, RP69
- Preventable Adverse Events, RP73
- Transfers Between Hospitals, RP75

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 16 - General Exclusions From Coverage, §110 - Custodial Care. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c16.pdf. Accessed 4/11/2025.
2. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §110.1 - Definition of Durable Medical Equipment, D. Definition of a Beneficiary's Home. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/11/2025.

3. CMS. Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, §3.6.2.2 - Reasonable and Necessary Criteria. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf. Accessed 4/11/2025.
4. CMS. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf. Accessed 4/11/2025.
5. CMS. Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services, §6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c06.pdf. Accessed 4/11/2025.
6. CMS. Quality Improvement Organization Manual, Chapter 4 - Case Review. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/qio110c04.pdf. Accessed 4/11/2025.
7. Centers for Medicare & Medicaid Services (CMS). Medicare General Information, Eligibility, and Entitlement, Chapter 4 – Physician Certification and Recertification of Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c04.pdf. Accessed 4/11/2025.
8. CMS. Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (CMS-4201-F). https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program. Accessed 4/11/2025.
9. CMS. FAQ for 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013. https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf. Accessed 4/11/2025.
10. CMS. Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §10.16 – Medical Necessity. Last updated 4/22/2016. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf. Accessed 4/11/2025.
11. 42 CFR 422.138(c). Last updated 4/12/2023. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.138. Accessed 4/11/2025.
12. CMS. Acute Hospital Care at Home Data Release Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/acute-hospital-care-home-data-release-fact-sheet. Accessed 4/11/2025.
13. CMS. CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge. https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge. Accessed 4/11/2025.
14. Medicare Managed Care Manual, Chapter 17, Subchapter B, Payment Principles for Cost-Based HMO/CMPs, §70 - Provider Receiving Payment Under the Prospective Payment System PPS. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c17b.pdf. Accessed 4/11/2025.
15. National Archives. Code of Federal Regulations 42 CFR § 412.3 https://www.ecfr.gov/current/title-42/section-412.3. Accessed 4/11/2025.
16. CMS. Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016. https://www.cms.gov/research-statistics-data-and-systems/monitoring-

programs/medicare-ffs-compliance-programs/medical-review/downloads/reviewing-short-stay-hospital-claims-for-patient-status.pdf. Accessed 4/11/2025.
17. CMS. Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c06.pdf. Accessed 3/10/2024.
18. CMS. Inpatient Only List 2025. CMS-1809-FC (See 2025 NFRM OPPS Addenda, Addendum E). https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip. Accessed 4/11/2025.
19. CMS. CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1772-FC). Published November 1, 2022. https://www.cms.gov/newsroom/factsheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatorysurgical-center-2. Accessed 4/11/2025.
20. CMS. CMS Manual System Pub 100-20 OneTime Notification. New Occurrence Span Code and Revenue Code for Acute Hospital Care at Home. Published January 20, 2022. https://www.cms.gov/files/document/r11191otn.pdf. Accessed 4/11/2025.
21. CMS. Acute Inpatient PPS. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps. Accessed 4/11/2025.

POLICY REVISION HISTORY

Date	Revision Summary
8/2024	New reimbursement policy
11/2024	Interim update, add reference to 42 CFR § 405.986
6/2025	Annual review, clarified use of CMS IPO list for Medicare Advantage and PEBB members, add rationale for use of policy criteria for Medicare Advantage members