Clinical Policy: Short Inpatient Hospital Stay

Reference Number: IL.CP.MP.182
Date of Last Revision: 08/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Medical necessity criteria for day one and day two of an inpatient hospital stay, excluding behavioral health and obstetrical delivery admissions.

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.[3]

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that day one and day two (if applicable) of an *inpatient hospital stay (vs. observation)* are **medically necessary** for one of the following indications:

A. Admission is for a procedure on the CMS 2026 Inpatient Only List for members/enrollees age 18 years and over (addendum E found here) or listed as a pediatric inpatient-only procedure in InterQual® for members/enrollees under 18 years of age;
B. Admission to an intermediate or intensive care unit level of care (including neonatal intensive care unit (NICU) is considered medically necessary per a nationally-recognized clinical decision support tool;
C. Admission to acute hospital care at home;[7]
D. Unexpected death during the admission;
E. Departure against medical advice from a medically necessary (per a nationally-recognized clinical decision support tool) inpatient stay;
F. Transferred from another facility, with a medically necessary (per a nationally-recognized clinical decision support tool) total length of stay greater than two days;
G. Election of hospice care in lieu of continued treatment in hospital.

II. It is the policy of health plans affiliated with Centene Corporation that inpatient hospital stays on day three and beyond are **medically necessary** when supported by nationally-recognized clinical decision support tools

III. It is the policy of Meridian Health Plan of Illinois that inpatient hospital stays (vs. observation) of one and two days that do not meet the indications listed above will be reviewed for medical necessity using nationally-recognized clinical decision support tools.

Background

Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.[1]

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. 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 two days and usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than two days.[3]

Centers for Medicare and Medicaid Services (CMS)- Inpatient Only List

The inpatient only list was established by CMS and identifies 1,700 procedures for which Medicare will pay only when performed in a hospital inpatient setting. Inpatient only services are generally, but not always, surgical services that require inpatient care because of the complexity of the procedure, the underlying physical condition of patients who require the service or the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged. There is no payment under the Outpatient Prospective Payment Systems (OPPS) for procedures that CMS designates to be "inpatient-only" services. The designation of services to be "inpatient-only" is open to public comment each year as part of the annual rulemaking process and many procedures have been added and removed over the years.[6]

Centers for Medicare and Medicaid Services (CMS)- Acute Hospital Care at Home

In November 2020, CMS announced the Acute Hospital Care at Home program to allow eligible hospitals expanded flexibility to care for patients in their homes. Hospital at home is designed to provide certain acute-level services in the home that patients would normally receive in the hospital setting. In-person physician evaluation is required prior to starting hospital at home care and patients may only be admitted from emergency departments and inpatient hospital beds. Acute Hospital Care at Home is for patients who require acute inpatient admission to a hospital and who require at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis.[7,8]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	02/20	03/20
Added to the description that "medical necessity criteria for day one and day two of an inpatient hospital stay, excluding behavioral health and obstetrical delivery admissions." Clarified that the medical necessity statement in I. applies to the first and second days of an inpatient stay. Added section II, stating that days 3 and beyond are medically necessary per nationally-recognized clinical decision support tools. Replaced all instances of member with member/enrollee.	10/20	11/20
References reviewed and updated. I.A. updated to specify "2020" Inpatient Only List. Background updated to include heading for CMS and information related to the Inpatient Only List and CY 2021 OPPS/ASC Final Rule.	02/21	03/21
In III, clarified that the statement refers to medically necessary stays supported by clinical decision support tools, vs. according to clinical decision support tools. Changed "Review Date" in the header to "Date of Last Revision," and "Date" in the revision log header to "Revision Date."	08/21	
Annual review. References reviewed and updated.	11/21	11/21
Replaced 2020 inpatient only list with 2022 inpatient only list in I.A. and updated references accordingly.	12/21	12/21
Annual review. Added I.C. "Acute hospital care at home." Background updated with no clinical significance. References reviewed and updated.	11/22	11/22
Annual review completed. Updated hyperlink to CMS inpatient only list in Criteria I.A. Added option in I.A. for procedure to be listed as an inpatient-only procedure in InterQual for those under 18 years of age, and noted that the CMS inpatient only list applies to those 18 years of age and older. Minor rewording with no clinical significance. References reviewed and updated. Internal specialist reviewed.	05/23	05/23
Illinois only section III added.	06/24	06/24
Annual Review; No significant changes	05/25	06/25
Annual Review; Update CMS 2025	08/25	09/25
Annual Review; Update CMS 2026	08/26	08/26

References

1. Centers for Medicare & Medicaid Services (CMS). Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016. (Last Updated: 12/31/2015). 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 April 5, 2023.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A. (Rev. 10892, 08/06/21). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf. Accessed April 5, 2023.
3. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B (Rev.10541 12/31/20). https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c06.pdf. Accessed April 5, 2023.
4. Centers for Medicare & Medicaid Services (CMS). Inpatient Only List 2023. https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip Accessed April 5, 2023.
5. Centers for Medicare & Medicaid Services (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/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2 Accessed April 5, 2023.
6. Centers for Medicare & Medicaid Services (CMS). Inpatient-only services. Medicare First Coast Service Options, Inc. https://medicare.fcso.com/Billing_news/0483382.asp. Accessed April 5, 2023.
7. Centers for Medicare & Medicaid Services (CMS). CMS Manual System Pub 100-20 One-Time 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 April 5, 2023.
8. Hospital-at-home. American Hospital Association. https://www.aha.org/hospitalathome. Accessed April 5, 2023.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.