Clinical Policy: Short Inpatient Hospital Stay

Reference Number: MI.CP.MP.182 Coding Implications
Last Review Date: 11/24 Revision Log

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

Description

Medical necessity criteria for hospital stays of less than three midnights, 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]

Note: For criteria applicable to Medicare plans, please see MC.CP.MP.182 Short Inpatient Hospital Stay.

Policy/Criteria

I. It is the policy of MeridianHealth that an inpatient level of care for hospital stays of less than three midnights is medically necessary when meeting one of the following indications::

A. Admission is for a procedure on the CMS 2024 Inpatient Only List for members/enrollees age 18 years and over (addendum E found at https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip) 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) considered medically necessary per a nationally-recognized clinical decision support tool with the exception of Diabetic Ketoacidosis and Drug Overdose;

C. Unexpected death during the admission;

D. Departure against medical advice from a medically necessary (per a nationally- recognized clinical decision support tool) inpatient stay;

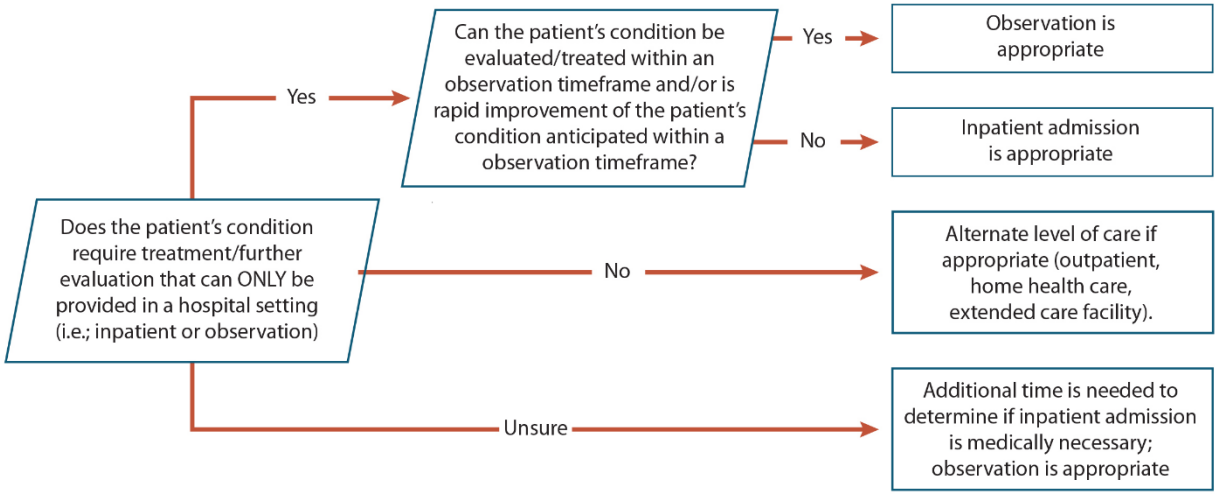
E. Transferred from another inpatient facility, with a medically necessary (per a nationally- recognized clinical decision support tool) total length of stay of three midnights or more;

F. Election of hospice care in lieu of continued treatment in hospital;

G. If the hospital stay is expected to require an inpatient level of care or exceed an observation timeframe. MeridianHealth utilizes the following decision tree developed by the Texas Medical Foundation (TMF) Health Quality Institute and supported by CMS to determine whether observation or an inpatient admission is appropriate in consideration of the patient's medical history and current medical needs, the natural course of the presenting disorder, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and

where the patient presents.

To aid the physician in determining when observation may be appropriate, this decision tree outlines the thought process for determining whether observation or inpatient admission is appropriate.



Disclaimer

This material was adapted from materials developed by MPRO, the Medicare Quality Improvement Organization for Michigan and TMF Health Quality Institute, the Medicare Quality Innovation Network-Quality Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. This content does not necessarily reflect CMS policy. 12SOW-QINQIO-CC-21-12

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 48 hours and usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 2 days.[3]

Centers for Medicare and Medicaid Services (CMS)- Inpatient Only List
The inpatient only list was established by CMS and identifies 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]

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 2019, 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	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date. Created market-specific version: • Added a decision tree that outlines the thought process for determining observation vs. inpatient admissions • Decision tree developed by the Medicare Quality Improvement Organization for Michigan and Texas Medical Foundation Health Quality Institute, the Medicare Quality Innovation Network-Quality	03/26/21	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Improvement Organization under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services • Assigned new market-specific policy number		
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. References reviewed and updated.	06/2023	06/2023
Annual review. Updated criteria I.A. from 2023 inpatient only link to 2024 link. Updated description and background with no clinical significance. References reviewed and updated.	06/2024	06/2024
Updated to policy description. Changed policy statement I. to "an inpatient level of care for hospital stays of less than three midnights is medically necessary…". clarified that the transfer is from an "inpatient" stay and changed "of two days or more" to "of three midnights or more." Updated policy statement II. to "inpatient hospital stays lasting three midnights and beyond…".	11/2024	11/2024

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). Accessed at: 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
2. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A. (). Accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloa ds/bp102c01.pdf
3. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B . Accessed at: https://www.cms.gov/media/125106
4. Centers for Medicare & Medicaid Services (CMS). Inpatient Only List 2024. https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip Accessed November 18, 2024.
5. Centers for Medicare & Medicaid Services (CMS). CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1786-FC). Published November 2, 2023. https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 Accessed November 18, 2024.
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 November 18, 2024.

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 members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions

expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.