Clinical Policy: Short Inpatient Hospital Stay

Reference Number: MC.CP.MP.182
Date of Last Revision: 04/24

Coding Implications
Revision Log

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

Description
Medical necessity criteria for an inpatient hospital stay spanning two midnights or less, 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.[4]

The criteria in I.A through I.C. of this policy are based off of 42 CFR §412.3.[1] Criteria I.B. and I.C. involve medical director review to verify that the complex medical factors in the medical record support the physician's expectation of the length of stay.[1] The examples in I.D. through I.I. provide additional options for circumstances that could necessitate a short inpatient stay, beyond what CMS specifically notes in 42 CFR §412.3, expanding access to appropriate payment of short inpatient stays beyond criteria CMS already considered appropriately as balancing risks and benefits.

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

Policy/Criteria

I. It is the policy of Medicare health plans affiliated with Centene Corporation® that inpatient *hospital stays (vs. observation)* spanning less than two midnights are **medically necessary** when meeting any of the following criteria:

A. Admission is for a procedure on the current calendar year CMS Inpatient Only List (2024 addendum E found here);[1]

B. The admitting physician expects the patient to require hospital care that crosses two-midnights based on consideration of complex medical factors documented in the medical record.[1] Such requests will be reviewed on a case-by-case basis by a medical director, considering factors such as member/enrollee history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event occurring during the time period for which hospitalization is considered;[1]

C. The admitting physician does not expect the patient to require care that crosses two midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary.[1] Such requests will be reviewed on a case-by-case basis by a medical director, considering factors such as member/enrollee history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event occurring during the time period for which hospitalization is considered;[1]

D. Admission to an intermediate or intensive care unit level of care is considered medically necessary per a nationally-recognized clinical decision support tool;
E. Admission to acute hospital care at home;[8]
F. Unexpected death during the admission;
G. Departure against medical advice from a medically necessary (per a nationally-recognized clinical decision support tool) inpatient stay;
H. Transferred from another facility, with a medically necessary (per a nationally-recognized clinical decision support tool) total length of stay greater than two days;
I. Election of hospice care in lieu of continued treatment in hospital.

II. It is the policy of Medicare 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.

Background

The expectation of the duration of the inpatient stay 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.[2]

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 two days.[4]

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.[7]

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.[8,9]

Centers for Medicare and Medicaid Services (CMS)- Final Rule 2024[10]
CMS states that a Medicare Advantage plan must cover an inpatient admission when, "based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the 'two midnight benchmark'); when admitting physician does not expect the patient to require care that crosses two-midnights, but determines, based on complex medical factors documented in the medical record that inpatient care is nonetheless necessary (§ 412.3(d)(3), the 'case-by-case exception'); and when inpatient admission is for a surgical procedure specified by Medicare as inpatient only (§412.3(d)(2))." Additionally, they clarify that "the 'two-midnight presumption' (the presumption that all inpatient claims that cross two midnights following the inpatient admission order are 'presumed' appropriate for payment and are not the focus of medical review absent other evidence) does not apply to MA plans. The two-midnight presumption is a medical review instruction given to Medicare contractors (for example, MACs, RACs, QIOs) to help them in the selection of claims for medical necessity review."

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 2023, 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	08/23	08/23
Annual review. Updated criteria I.A. by removing 2023 inpatient only link. Updated description and background with no clinical significance. References reviewed and updated.	04/24	04/24

References

1. National Archives. Code of Federal Regulations 42 CFR § 412.3 https://www.ecfr.gov/current/title-42/section-412.3. Accessed April 8, 2024.
2. Centers for Medicare & Medicaid Services (CMS). Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016. Updated December 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 8, 2024.
3. 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 8, 2024.
4. 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 8, 2024.
5. 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 8, 2024.
6. 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 April 8, 2024.
7. 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 8, 2024.
8. 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 8, 2024.
9. Hospital-at-home. American Hospital Association. https://www.aha.org/hospitalathome. Accessed April 8, 2024.
10. Centers for Medicare & Medicaid Services (CMS). Medicare Program; 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. Published April 12, 2023. federalregister.gov/d/2023-07115. Accessed April 8, 2024.
11. 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 April 8, 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 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.

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, member/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, member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to member/enrollees and/or submitting claims for payment for such services.

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.

Note: For Medicare member/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.