Prior Authorization Requests and Level of Care Determinations

LOB(s):	State(s):
☒ *Commercial* ☒ *Medicare*	☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

PacificSource utilizes MCG™ Care Guidelines for assessing medical necessity for inpatient stays and for prior authorizations that request a corresponding inpatient stay.

Criteria

Commercial, Medicaid, and Medicare

PacificSource will use MCG™ Care Guidelines for initial determinations regarding inpatient level of care and expected length of stay. When clinically appropriate, the UM Clinician may authorize fewer than the MCG™ Care Guidelines goal length of stay (GLOS) based on the individual clinical circumstances. Ongoing inpatient review processes apply.

PacificSource will not prior authorize an inpatient stay for a prior authorization request, when MCG™ Care Guidelines indicate a particular procedure can be performed at an ambulatory level of care. Requests for inpatient level of care in these circumstances should follow the regular inpatient notification and review processes.

Note: For members on a "Legacy Employee Health Plan" (LEHP) plan, prior authorization of procedures performed at Legacy facilities and/or any admission to Legacy facilities are not subject to level of care (inpatient/ambulatory and goal length of stay) criteria or policies.

Definitions

Goal Length of Stay (GLOS) – MCG's recommended number of days a patient should be in the hospital for a specific condition or procedure, based on evidence and best practices.

Related Policies

Clinical Criteria Used in UM Decisions

Medical Necessity Reviews

Medicaid and Medicare Authorizations

References

MCG Health. Guidelines for Ambulatory Care

MCG Health. Guidelines for Inpatient & Surgical Care

Appendix

Policy Number:

Effective: 7/1/2025 **Next review:** 7/1/2027

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s): OAR 410-120-1320, 410-141-3820, 410-141-3825

External entities affected:

OPs Approval: 5/2026