



## Inpatient Hospital Short-Stays

<b>LOB(s):</b> <input checked="" type="checkbox"/> Commercial  <input checked="" type="checkbox"/> Medicare	<b>State(s):</b> <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other:
<input checked="" type="checkbox"/> Medicaid	<input checked="" type="checkbox"/> 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

The determination of whether a hospital stay is medically necessary, regardless of length, is based on a holistic assessment of the member's clinical presentation and needs. This includes a thorough review of the individual's medical history, existing comorbid conditions, the severity and acuity of presenting signs and symptoms, the immediacy and intensity of treatment required, and the clinical judgment surrounding potential risks or complications if care were delayed or provided in a less intensive setting. These factors are weighed in the context of the anticipated clinical course and the expected timeframe for stabilization or resolution of the medical condition.

Observation services are typically initiated when a member presents to the emergency department with conditions requiring further diagnostic evaluation or therapeutic intervention, but where the need for full inpatient admission is not immediately clear. Observation allows for continuous clinical assessment, treatment initiation, and reevaluation within a controlled setting. In most situations, a determination about the appropriate disposition of the patient, either discharge or inpatient admission can be made within 24 to 48 hours. Instances in which observation services extend beyond two calendar days are uncommon and typically involve extenuating clinical complexities requiring justification.

In support of appropriate level-of-care decisions, PacificSource aligns with Centers for Medicare & Medicaid Services (CMS) guidance, particularly regarding the CMS Inpatient Only (IPO) List. This list specifies procedures that are reimbursable by Medicare only when performed in the inpatient setting, typically, due to the procedure's complexity, the need for extended postoperative monitoring, or

heightened clinical risk. While originally designed for Medicare populations, the principles of the IPO list are often instructive for determining the appropriate setting of care in non-Medicare populations as well.

Additionally, PacificSource recognizes the evolving care delivery models such as the CMS-approved Acute Hospital Care at Home program. This model enables qualified hospitals to deliver hospital-level care in the member's home under strict clinical criteria, including pre-admission assessment, daily physician oversight, and continuous remote or in-person monitoring. These alternative pathways to inpatient care offer flexibility while preserving patient safety and clinical quality. The Acute Hospital Care At Home Program is subject to member benefit handbook contract exclusions and explanation of coverage (EOC).

All determinations of medical necessity for inpatient or observation care are guided by evidence-based clinical decision support tools (e.g., MCG, PacificSource policy) and align with regulatory requirements and industry best practices. Billing and coding practices are expected to reflect the actual services provided, and services related to short inpatient stays must be bundled appropriately when clinically and administratively indicated.

This policy defines criteria under which inpatient admission of fewer than three midnights may be considered medically necessary for members, excluding behavioral health and obstetric deliveries.

## Criteria

---

### Commercial

PacificSource Health Plans may authorize an inpatient level of care for hospital stays under three midnights when specific medical necessity criteria are met. For requests with an expected length of stay less than 48 hours refer to the Hospital Services – Observation Level of Care policy.

- A.** PacificSource may consider inpatient level of care hospital short-stays under three midnights medically necessary when **ONE** of the following conditions are met:
1. The procedure is listed on the current CMS Inpatient Only (IPO) list for adults, or on an inpatient-only procedure list for pediatric populations per an industry-recognized guideline (e.g., MCG or InterQual).
  2. The admission is to an intensive care unit (ICU), intermediate care unit, or neonatal intensive care unit (NICU), and the clinical decision support tool in use validates the need for this level of care.
  3. The member is admitted to a qualified Acute Hospital Care at Home program that meets established regulatory, clinical oversight standards, and coverage benefits.

**Note:** PacificSource Commercial Acute Hospital Care at Home providers must be contracted with PacificSource. St. Luke's contract will include a provision to provide Acute Hospital Care at Home, effectively on 1/1/2026.

4. The member expires during hospitalization before a longer length of stay occurs.
5. The member leaves against clinical recommendation during an otherwise medically necessary inpatient stay.
6. The member is transferred from another acute facility, and the total inpatient episode of care across facilities meets or exceeds three midnights based on appropriate criteria.

7. The member elects hospice care during their hospitalization, shifting from curative to comfort-focused treatment.

## Medicaid

PacificSource Community Solutions (PCS) follows the criteria above for Non-EPSDT Beneficiaries.

**Note:** PCS does not cover Acute Hospital Care at Home Program at this time.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for members under 21 or Young Adults with Special Health Care Needs (YSHCN). Third Level Reviewers perform case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness, as defined in OAR 410-151-0001, prior to denying level of care requests.

## Medicare

PacificSource Medicare follows 42 CFR §412.3 for Inpatient Hospital Short-Stays.

**Note:** PacificSource Medicare follows the two-night benchmark for hospital short-stays. For which, it is reasonably expected to stay at least two midnights. This includes stays in which the physician expectation is supported, but the length of stay was less than two midnights due to unforeseen circumstances (e.g., unexpected death, transfer, clinical improvement, or against medical advice discharge).

- For stays expected to last less than two midnights of hospital care, an inpatient admission may be payable on a case-by-case basis based on the judgement of the admitting physician

**Note:** Centers for Medicare & Medicaid Services (CMS) requires a provider submit and receive an approved waiver of Hospital Conditions of Participation, in order to provide the Acute Hospital Care at Home program.

## Definitions

---

**Inpatient** – level of care when a patient is admitted to a hospital.

**Observation** – level of care with a defined set of clinically appropriate services, including continuous short-term treatment, evaluation, and reassessment, provided while determining whether a patient requires inpatient admission or can be safely discharged. These services are typically ordered for patients presenting to the emergency department who need extended monitoring or treatment to support the admission or discharge decision

**Short Stays Under Two Midnights** – Inpatient admissions where the physician expects the patient to need less than two midnights of hospital care are generally not considered appropriate for Part A payment unless there are exceptional circumstances, such as the procedure being on the "inpatient-only" list or a national exception.

## Related Policies

---

Clinical Criteria Used in UM Decisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Hospital Services - Observation Level of Care

## References

---

American Hospital Association™. Hospital-at-Home. <https://www.aha.org/hospitalathome>

Centers for Medicare & Medicaid Services. (2026). 42 CFR § 412.3—Admissions. Electronic Code of Federal Regulations. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-A/section-412.3>

Centers for Medicare and Medicaid Services (CMS). (October 30, 2015). Fact Sheet: Two-Midnight Rule. <https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0#:~:text=No%20change%20for%20stays%20over,or%20departure%20against%20medical%20advice.>

Centers for Medicare and Medicaid Services (CMS). (July 8, 2025). Inpatient Hospital Reviews FAQs. <https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/inpatient-hospital-reviews-faqs>

Centers for Medicare and Medicaid Services (CMS). (2025). Medicare Program: Hospital Outpatient Prospective Payment System - Final Rule (CMS-1809-FC). <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc>

Centers for Medicare & Medicaid Services (CMS). (January 20, 2022). CMS Manual System Pub 100-20 One Time Notification. New Occurrence Span Code and Revenue Code for Acute Hospital Care at Home. <https://www.cms.gov/files/document/r11191otn.pdf>

## Appendix

---

**Policy Number:**

**Effective:** 7/1/2025

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

**Policy type:** Enterprise

**Author(s):**

**Depts.:** Health Services

**Applicable regulation(s):** 42 CFR §482.23(b) and (b)(1); 42 CFR §412.3; OARs 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002

**External entities affected:**

**OPs Approval:** 5/2026