Inpatient Hospital Short-Stays Short-Stays

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

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.

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 midnight when specific medical necessity criteria are met. Observation care is intended for short-term monitoring, reassessment, and treatment while determining if a member can be safely discharged or requires continued inpatient care. For requests with an expected length of stay less than 48 hours refer to the Hospital Services – Observation Level of Care.

PacificSource may consider inpatient level of care hospital short-stays under three midnight medically necessary when **ONE** of the following conditions are met:

- **A.** 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).
- **B.** 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.
- **C.** The member is admitted to a qualified Acute Hospital Care at Home program that meets established regulatory and clinical oversight standards.
- **D.** The member expires during hospitalization before a longer length of stay occurs.
- **E.** The member leaves against clinical recommendation during an otherwise medically necessary inpatient stay.
- **F.** 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.
- **G.** 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.

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 CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

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

Medical Necessity Reviews

References

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

Centers for Medicare and Medicaid Services (CMS). CMS-1809-FC: Hospital Outpatient Prospective Payment-Notice of Final Rulemaking. 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:** 7/1/2026

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): OARs 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002

External entities affected: N/A

Commercial OPs: 7/2025

Government OPs: 7/2025