moda HEALTH	**Reimbursement Policy Manual**	**Policy #:**	**RPM067**
Policy Title:	**Level of Care Review**		
Section:	**Facility-Specific**	**Subsection:**	**None**

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☒ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	10/12/2009	Initially Published:	4/10/2019
Last Updated:	12/14/2022	Last Reviewed:	12/14/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		12/14/2022	

Reimbursement Guidelines

A. Overall Policy Statement

1. The purpose of the Level of Care (LOC) Review is to ensure correct billing practices are utilized by all hospitals so that appropriate reimbursement is made.
    a. Review facility claims and corresponding medical records for appropriate level of care.
    b. Inform facilities of our review findings.
2. The Level of Care Review examines hospital claims for the following:
    a. A short length of stay billed with a DRG or an extended stay billed as observation, to determine the appropriate level of care.
    b. Special care unit length of stay.

B. Process

1. Inpatient acute care claims submitted for payment are selected for review using Moda criteria.
2. If the claim is to be reviewed, the medical record is requested. A Hospital Auditor Registered Nurse (RN) reviews the record for severity of the illness and the intensity of the service provided to determine if the appropriate level of care was submitted for reimbursement.

3. Resources utilized for this review process include the Milliman Care Guidelines (MCG) for level of care criteria and Moda Medical Director determination.
4. The Medical Director provides input for cases where inpatient criteria are not met, or unusual circumstances are found.
5. Moda provides individual case summaries and the rationale used in making a change recommendation, to the Medical Director, when disagreement with the original claim submission occurs.
6. Notification will be sent to the facility with a detailed explanation for the change.

C. Inpatient Status versus Outpatient Observation Status Considerations

1. The need to change the patient status depends on many factors, including the care rendered, the intensity of the services, and the severity of the illness.
2. Observation involves active treatment and care. A diagnosis and treatment plan may be present in observation status.
3. The physical location of the service may be the same for observation and inpatient Care—Including ICU or CCU.
4. Observation care is reimbursable up to 48 hours. However, the length of time in the facility does not determine the appropriate level of care.
5. Length of stay beyond one overnight does not automatically make a claim an inpatient stay and is not determined by time in the facility.
6. Observation status is appropriate when (list is not all inclusive):
    a. The need for an inpatient admission cannot be medically determined; or
    b. Additional time is needed to evaluate the patient; or
    c. The patient responds rapidly to treatment; or
    d. The care needed is not intense; or
    e. The patient is not acutely ill.
7. Moda allows the provider the opportunity to rebill a claim that should be paid at an observation/ambulatory level of care.
8. Treatments such as IV fluids and IV antibiotics alone would not automatically qualify for inpatient status.
9. It is appropriate to start as observation status when the working diagnosis is a symptom, a rule out, or a possible condition.
10. Normal, expected postoperative conditions that may extend the treatment, such as pain or nausea and vomiting, would not automatically qualify for inpatient status.
11. “Failed outpatient” alone may not qualify for inpatient status. Each case is reviewed on its individual circumstances and considerations.

D. Observation Reimbursement

1. Moda Health reimburses for up to 48 hours of observation, if clinically appropriate.

2. Observation stays billed beyond 48 hours will be reviewed for clinical level of care.
    a. Observation stays longer than 48 hours that do not meet clinical guidelines for inpatient level of care will be processed as observation and hours of observation care and charges after 48 will be denied per the CMS (Centers for Medicare and Medicaid Services) outpatient reimbursement terms.
    b. Moda Health follows CMS guidelines regarding proper documentation of observation stays.

E. Correct Billing Of Facility Fees For Observation Stays

1. Hospitals are to report observation services using the following procedure codes: (CMS[26])
    a. G0378 *Hospital observation service, per hour*.
    b. If applicable, G0379 *Direct admission of patient for hospital observation care* may be appropriate to report.
2. Procedure codes 99234 – 99236 may not be reported by hospitals for observation facility fees. These codes are for reporting professional E/M services when the patient is in observation or inpatient hospital care and is admitted and discharged on the same calendar date. (CMS[27])

F. Special Care Unit Length of Stay (LOS)

1. Special care units include, but not limited to:
    a. Intensive Care Unit (ICU)
    b. Coronary Care Unit (CCU)
    c. Neonatal Intensive Care Unit (NICU)
    d. Pediatric Intensive Care Unit (PICU)
    e. Step-down Care Unit
2. When the length of stay (LOS) in a special care unit extends beyond what is supported by the level of care criteria, the excess days will be reimbursed at the rate for the lower level of care.

G. Milliman Care Guidelines (MCG)

1. Milliman Care Guidelines (MCG) is/are:
    a. A nationally recognized level of care criteria.
    b. A nurse review tool that fosters reliable, uniform, rule-based decisions and contains measurable clinical information.
    c. Used for screening the appropriateness of acute hospital levels of care.
    d. Organized by body systems.
2. Criteria subsets include:
    a. Observation.
    b. Critical Care.
    c. Intermediate Care.

d. Acute Care.

3. The MCG Criteria considers both the patient's "Severity of Illness" and the "Intensity of Service". The criteria represent the clinical factors that are reviewed in order to establish the necessity for acute, inpatient care.
4. "Severity of Illness" is objective clinical indicators of illness. (MCG[1])
5. "Intensity of Service" is diagnostic, monitoring, and therapeutic services that can only be administered at a specific level of care. (MCG[1])
6. A Medical Director reviews cases that do not meet the MCG Level of Care criteria.

H. Special information for Medicare Advantage line of business:

1. Moda applies the above policy and processes to Medicare Advantage claims except where the above considerations differ from Centers for Medicare and Medicaid Services (CMS). In those instances of a difference of policy, all applicable CMS guidelines apply for ambulatory, outpatient, observation, and inpatient (Noridian[12], Novitas[13, 14, 15, 16, 17]) claims that are reviewed for determining the level of care.
2. For Medicare Advantage claims, Moda Health follows the CMS guidelines for the *Medicare Outpatient Observation Notice* (MOON), form *CMS-10611,* for Medicare beneficiaries receiving outpatient observation care for more than 24 hours. All hospitals, including critical access hospitals, are required to begin providing this notice no later than March 8, 2017. (CMS [7, 8, 9, 10])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see "NCCI")
CCU	=	Coronary Care Unit, or Critical Care Unit
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
ED	=	Emergency Department (also known as/see also ER)
ER	=	Emergency Room (also known as/see also ED)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")

Acronym or Abbreviation		Definition
HIPAA	=	Health Insurance Portability and Accountability Act
ICD	=	International Classification of Diseases
ICD-10	=	International Classification of Diseases, Tenth Edition
ICD-10-CM	=	International Classification of Diseases, Tenth Edition, Clinical Modification
ICD-10-PCS	=	International Classification of Diseases, Tenth Edition, Procedure Coding System
ICU	=	Intensive Care Unit
LOC	=	Level of Care
LOS	=	Length of Stay
MCG	=	Milliman Care Guidelines
MOON	=	Medicare Outpatient Observation Notice
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
NICU	=	Neonatal Intensive Care Unit
OPPS	=	Outpatient Prospective Payment System
PICU	=	Pediatric Intensive Care Unit
POA	=	Present on Admission
RN	=	Registered Nurse
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
TOB	=	Type of Bill
UB	=	Uniform Bill
UHDDS	=	Uniform Hospital Discharge Data Set

Definition of Terms

Term	Definition
Intensity of Service	Diagnostic, monitoring, and therapeutic services that can only be administered at a specific level of care. (MCG[1])
Level of care	The intensity of effort required to diagnose, treat, preserve or maintain an individual's physical or emotional status. (CMI[11])
Severity of Illness	Objective clinical indicators of illness. (MCG[1])

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Facility Guidelines, General Overview." Moda Health Reimbursement Policy Manual, RPM065.

References & Resources

1. Milliman Care Guidelines (MCG).

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3. CMS. "Clarification of Admission Order and Medical Review Requirements." Pub 100-02 Medicare Benefit Policy Manual. Transmittal 234. March 10, 2017. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R234BP.pdf .

4. CMS. "Hospital Services Covered Under Part B." Pub 100-02 Medicare Benefit Policy Manual, chapter 6.

5. CMS. "General Billing Requirements." Pub 100-04 Medicare Claims Processing Manual, chapter 1.

6. CMS. "Part B Hospital (Including Inpatient Hospital Part B and OPPS)." Pub 100-04 Medicare Claims Processing Manual, chapter 4.

7. CMS. "Part A Medicare Outpatient Observation Notice, Scope." *Medicare Claims Processing Manual* (Pub. 100-04). Chapter 30 - Financial Liability Protections, § 400.2.

8. CMS. "Part A Medicare Outpatient Observation Notice." *Medicare Claims Processing Manual* (Pub. 100-04). Chapter 30 - Financial Liability Protections, § 400 – 400.4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

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15. Novitas Solutions, Inc. “Inpatient vs. Observation How to Decide.” Last updated October 12, 2021; Last accessed November 7, 2022. https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00003070 .

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20. CMS. “Complying with Medicare Signature Requirements.” Medicare Learning Network. MLN905364. April 2022. Last accessed June 2, 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf.

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Background Information

Observation care and inpatient hospital care are different levels of care reimbursed under very different payment methodologies. The level of care is not determined by the location of the patient nor by the length of time in the facility. Specific criteria is used, and reviews are performed to ensure correct billing and reimbursement.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
12/14/2022	Clarification/Update: Section E: Added clarification of correct codes for hospitals to use for billing observation services with 2 related footnote sources.
11/9/2022	Formatting/Update: Change to new header; includes Idaho. Section F: Minor rephrasing/re-ordering. No content changes. Cross References: Hyperlinks added. References & Resources: 13 entries added as additional resources for section G Noridian footnote & references.
5/11/2022	Clarification/update. Added information about special care unit LOS reviews. These have been occurring (concurrent, pre-pay, post-pay) but were not previously mentioned in the policy. Scope: Added Summit Health. Acronym table: Added 11. Policy History: Added. Entries prior to 2022 omitted (in archive storage).
4/10/2019	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/12/2009	Original Effective Date (with or without formal documentation). Policy based on CMS Pub. 100-04, ch. 4, § 290.1 and § 290.5.3 (CMS[6]) and MCG[1].