Scope
This policy applies to inpatient hospital and observation claims for all Commercial medical plans and Medicare Advantage plans.

Reimbursement Guidelines

A. Overall Policy Statement
   1. The Level of Care Review examines hospital claims that have a short length of stay billed with a DRG or an extended stay billed as observation, to determine the appropriate level of care.
   2. 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.

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 Judgement.
   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. Milliman Care Guidelines (MCG)

1. A nationally recognized level of care criteria.
2. A nurse review tool that fosters reliable, uniform, rule-based decisions and contains measurable clinical information.
3. Used for screening the appropriateness of acute hospital levels of care.
4. Criteria subsets include:
   a. Observation.
   b. Critical Care.
   c. Intermediate Care.
   d. Acute Care.
5. Organized by body systems.
6. The MCG Criteria considers both the patient’s “Severity of Illness” and the “Intensity of Service”. The criteria represents the clinical factors that are reviewed in order to establish the necessity for acute, inpatient care.
7. “Severity of Illness” is objective clinical indicators of illness. (MCG1)
8. “Intensity of Service” is diagnostic, monitoring, and therapeutic services that can only be administered at a specific level of care. (MCG1)
9. The Moda Medical Director reviews cases that do not meet the MCG Level of Care criteria.

F. 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 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 Defined

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<td>CAH</td>
<td>Critical Access Hospital</td>
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<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<td>DRG</td>
<td>Diagnosis Related Group (also known as/see also MS DRG)</td>
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<td>ED</td>
<td>Emergency Department (also known as/see also ER)</td>
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<td>ER</td>
<td>Emergency Room (also known as/see also ED)</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System (acronym often pronounced as &quot;hick picks&quot;)</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>ICD-10</td>
<td>International Classification of Diseases, Tenth Edition</td>
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<tr>
<td>ICD-10-PCS</td>
<td>International Classification of Diseases, Tenth Edition, Procedure Coding System</td>
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<tr>
<td>LOC</td>
<td>Level of Care</td>
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<td>MCG</td>
<td>Milliman Care Guidelines</td>
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<td>MOON</td>
<td>Medicare Outpatient Observation Notice</td>
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<td>MS DRG</td>
<td>Medicare Severity Diagnosis Related Groups (also known as/see also DRG)</td>
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<tr>
<td>OPPS</td>
<td>Outpatient Prospective Payment System</td>
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<td>POA</td>
<td>Present on Admission</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>TOB</td>
<td>Type of Bill</td>
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<td>UHDDS</td>
<td>Uniform Hospital Discharge Data Set</td>
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### Definition of Terms

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<tr>
<td>Intensity of Service</td>
<td>Diagnostic, monitoring, and therapeutic services that can only be administered at a specific level of care. (MCG(^1))</td>
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<tr>
<td>Severity of Illness</td>
<td>Objective clinical indicators of illness. (MCG(^2))</td>
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Cross References


References & Resources

1. Milliman Care Guidelines (MCG).


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 Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should 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/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.