POLICY

	Policy No: MHI-HCS-394
	Policy Title: Clinical Determinations of Appropriate Level of Care
	Department: Healthcare Services (HCS) **Sub-Department:** Utilization Management
Entity: Molina Healthcare, Inc. **State(s):** AZ, CA, CT, FL, ID, IL, KY, MA, MI, MS, NE, NV, NM, NY, OH, SC, TX, UT, WA, WI	**Effective Date:** 5/2/2016
Name: Lisa Ledford-Crissey **Title:** SVP, Clinical Operations	**Signature**: Lisa Ledford-Crissey

Lines of Business:

☐ All ☐ Medicare ☒ Marketplace

☒ Medicaid ☐ Medicare-Medicaid Programs (MMP) ☐ Other: _____

I. PURPOSE

The use of observation is an alternative to inpatient admission that allows for a period of treatment or assessment, pending a decision regarding the need for additional care. This will determine if inpatient admission is necessary or whether observation services would have sufficed. Proper use of observation status and inpatient admission will ensure that the appropriate level of care (LOC) is used for the medically necessary care that was given.

The LOC, not the physical location of the bed, dictates admission status. Hospitals can use specialty areas (including CCU or ICU) to provide observation services. Continuous monitoring, such as telemetry, can be provided in an observation or inpatient status. In determining admission status, overall severity and intensity of the services will be considered rather than any single or specific intervention. In the absence of a designated outpatient observation unit, outpatient observation members may be placed in any available acute care bed. A member's status can change from outpatient observation to inpatient without actually changing beds. Care and treatment in outpatient observation status can be the same as inpatient care, and an outpatient observation member may progress to inpatient status when it is determined that the member's condition requires an inpatient LOC. Conversion from observation status to inpatient status must meet medical necessity.

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether a member will require further acute inpatient treatment in the hospital or if they are able to be discharged. Observation care spans the gap between outpatient and inpatient care.

Observation care may be appropriate when time beyond outpatient or emergency department care is required for continued assessment of the member. For example:

A. Testing or reevaluation is needed to determine the member's diagnosis and care needs
B. The initial history, symptoms, signs, and/or diagnostic tests are inconclusive, but the member is clinically stable
C. To determine whether the member's response to treatment is adequate
D. The member's immediate condition is not life-threatening and initial response to treatment is favorable

E. The member shows initial and progressive improvement with treatment suggesting rapid resolution of the presenting problem
F. The member requires medication adjustments or hydration management
G. The member requires pain management
H. The member has post procedural complications which do not require an inpatient LOC but necessitate ongoing monitoring

Observation or inpatient orders must be in writing by a physician, or other individuals authorized by hospital staff bylaws. The Centers for Medicare and Medicaid (CMS) does not consider the use of inpatient or observation as a convenience of the member, the member's family, or a physician to be appropriate.

Inappropriate use of inpatient status includes:
A. Members maintained on-site due to socioeconomic factors
B. Members held at physician convenience for later testing or examination
C. Members on-site in preparation for, or in routine recovery from, ambulatory procedures
D. Members on-site for routine outpatient procedures (i.e., transfusion or chemotherapy)
E. Services routinely performed in the emergency department or outpatient setting
F. Custodial care

In the majority of cases, the decision whether inpatient admission or discharge is warranted can be made in less than 48 hours. In certain situations, outpatient observation services may span more than two calendar days. Outpatient observation stays exceeding 23 hours are not automatically converted to inpatient admissions. Observation stays may continue to be extended as needed for ongoing assessments and decision making. Conversion from observation status to inpatient status must meet medical necessity. Molina Healthcare, Inc. (hereinafter referred to as "Molina") applies an evidence based clinical criteria guideline for inpatient and observation status reviews, as long as the methodology complies with Federal or State regulations and the Hospital or Provider Services Agreement.

The role for observation is included in well recognized national criteria sets. The patient receiving observation services may improve and be released or be admitted as an inpatient. Guidelines, such as InterQual and MCG, may serve as guidance and clinical screening criteria for initial review of the appropriate use of observation care versus inpatient care by nursing staff. Guidelines are screening tools and are not intended to be a substitute for Medical Director judgment. Only physicians can determine the clinical inappropriateness of requests. Molina's Medical Director reviewers may refer to guideline criteria in reaching the determination but are not required to adhere to any single published criteria.

Molina follows these standards in making a determination regarding the payment methodology to be used for acute hospital care. Molina will pay for hospital care as an inpatient for those stays where there is a clear expectation, and the medical record supports that reasonable expectation of an extended stay, or where observation has been tried in those patients that require a period of treatment or assessment and the observation LOC has failed.

Molina does not require an authorization for observation LOC but does require an authorization for inpatient.

Molina requires clinical review for all medical necessity decisions. All Molina professionals reviewing cases for medical necessity need sufficient clinical information to make the appropriate medical necessity determination.

II. POLICY

A. In accordance with the Hospital Service Agreement, Molina shall coordinate utilization review (telephonic, on-site, electronic) with hospital staff for inpatient admissions of Molina members concurrent with the admission.

B. Molina requires clinical review for all medical necessity decisions. All Molina professionals reviewing cases for medical necessity must review sufficient clinical information to make the appropriate medical necessity determination.

1. These procedures are in accordance with the contract terms between Molina and its contracting hospitals, Federal and State requirements, and applicable accreditation standards.

2. Decisions are supervised by qualified medical professionals and all medical necessity denials are made by a Medical Director.

3. Molina uses Federal and State regulations, policies, and benefit guidance as well as nationally accepted evidence-based criteria guidelines for decision making.

4. Complete and thorough clinical information is required to conduct inpatient clinical review. The Clinician will provide notice to the facility/provider requesting additional clinical information when needed. If clinical information is not received in a timely manner, then a non-approval may be issued. Typical clinical information that is considered for an inpatient admission includes:
    a. Severity of the signs and symptoms exhibited by the member
    b. The medical predictability of something adverse happening to the member
    c. The need for diagnostic studies that cannot be done on an outpatient basis
    d. The ordering physician's judgement and rationale for inpatient LOC

5. The inpatient care is required if the member's medical condition, safety or health would be significantly and directly jeopardized if care were provided in a less intensive setting.

III. SCOPE

Clinical Management and Policy; Healthcare Services (HCS); MHI Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS)

IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS), Claims

V. DEFINITION(S)

Acceptable Clinical Information – includes but not limited to: History and Physical, Emergency room notes, Medication records, Physician orders, laboratory values and any supporting clinical documentation for the requested level of care. Hospital case management reviews cannot take the place of clinician's documentation.

Clinician – A licensed healthcare professional that conducts utilization management review including but not limited to physicians, nurses, and behavioral health professionals.

Observation – is an alternative to inpatient admission (and consequently it is considered an outpatient status). Centers for Medicare and Medicaid Services (CMS) stipulates that "observation care is a well-defined set of specific, clinically appropriate services...that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital."

VI. REFERENCE(S)

MHI-HCS-394.01 Clinical Determination of Appropriate Level of Care Procedure

VII. VERSION CONTROL

Version No	Date	Revision Author/Title	Summary of Changes
1	1/6/2022	J. Cruz/VP Clinical Operations	Annual review, new P&P template (previous revision dates- 12/05/2016, 08/07/2017, 09/26/2018, 04/23/2020, 07/23/2020, 10/19/2020, 06/28/2021)
2	11/9/2022	J. Cruz/VP Clinical Operations	Annual Review
3	12/12/2023	J. Cruz/VP Clinical Operations	Annual Review; States: removed IA, added NE, TX (for TX MC products); Reinstated for Medicare/MMP (applies to all LOB); Section I., 8th paragraph - removed "for Medicaid/MP LOB"; Scope: added Office of CMO; References: added MC Benefit Policy Manual and connected procedure; minor formatting (including hierarchical) changes.
4	05/14/2024	Melissa Scharff, RN/Director of Healthcare Services	Revision; II.A.4.d. redesignated as II.A.4.e; added new II.A.4.d.; Scope: replaced Office of CMO with Clinical Mgmt. & Policy, MHI CMO Policy & Benefit, and MCS
5	12/18/2024	Christa Ross/AVP Clinical Operations	Revision; States: removed TX; LOB: revised from All LOB to Medicaid and Marketplace (retire for Medicare/MMP – not applicable); References: removed Medicare Benefit Policy Manual
6	02/07/2025	Christa Ross/AVP Clinical Operations	Revision; States: added TX (for MKP); V. Definitions: removed CRC and added Clinician; VI. Reference: removed State Medicaid and ACA Regulations
7	11/20/2025	Christa Ross/ VP Clinical Programs & Services	Annual review - States: added CT, removed VA; Updated signature owner; Policy No.: added MHI-; Sub-Dept.: added UM; II.B.2. "non-approval decisions" reworded as "denials"; II.B.4. removed "Only a Med. Dir., Pharm. or Psychiatrist can render a non-approval decision." (duplicative of II.B.2.); II.B.4.e. redesignated as II.B.5.; References: updated connected Proc. No.