PCHP Reimbursement Policy		
Topic: Appropriate Level of Care Reimbursement	Policy Number: PCHP.RI.001	Policy Section: Clinical
Last Modification Date:	Effective Date: 5/15/2025	

Policy Disclaimer:

Please ensure adherence to correct billing and submission protocols. Utilize industry-standard, compliant codes when submitting claims. Services should be coded using Current Procedure Terminology® (CPT), Healthcare Common Procedure Coding System (HCPCS), and/or revenue codes. These codes specify the services or procedures rendered and must be fully substantiated in the medical record or office notes upon billing. Our reimbursement policies apply uniformly to both participating and non-participating professional providers and facilities, unless stated otherwise.

Failure to comply with appropriate coding/billing guidelines or current reimbursement policies may result in actions by PCHP, including claim rejection or denial, claim payment recovery/recoupment, or reimbursement adjustment to accurately reflect the services provided.

These reimbursement policies are designed to support you in submitting accurate claims and to clarify the criteria for reimbursement if PCHP covers the service under the member's benefit plan; however, coverage determination for items such as, but not limited to service, procedure, item, do not guarantee reimbursement. All billed services must align with authorization and medical necessity guidelines.

These reimbursement policies may be overridden by mandates in provider contracts, state or federal regulations, or Centers for Medicare & Medicaid Services (CMS) requirements. PCHP strives to implement policy changes promptly; any delays may necessitate recoupment of claims payment to the effective date as outlined in the policy. We reserve the right to periodically review and update these policies as needed, with the most current version available on our website upon any revisions.

Policy:

PCHP or its designated entity may conduct clinical and claim validation reviews, both prior to and following payment, to verify DRG assignments and ensure appropriate reimbursement for facility stays. This process is essential to guarantee that claims accurately reflect the services provided to our members and that billing and reimbursement align with federal and state regulations, as well as applicable standards, rules, laws, policies, and contract provisions.

The determination of admission status is based on the level of care needed, rather than the physical location of the bed. Hospitals can utilize specialty areas such as CCU or ICU to deliver observation services, including continuous monitoring like telemetry, whether in observation or inpatient status. Admission status is determined by the overall severity and intensity of services provided, rather than any single or specific intervention.

In the absence of a designated outpatient observation unit, members requiring outpatient observation may be accommodated in any available acute care bed. Members in outpatient observation status may transition to inpatient status without a change in physical location, based on the assessment that their condition requires inpatient-level care, as determined by medical necessity.

Observation care encompasses specific and clinically appropriate services, including ongoing short-term treatment, assessment, and reassessment, aimed at determining whether further acute inpatient treatment is required or if discharge is appropriate. This type of care bridges the gap between outpatient and inpatient settings and may be necessary when additional time beyond outpatient or emergency care is needed for continued member assessment.

Examples of when observation care may be appropriate include situations where testing or reevaluation is necessary for diagnosis and care planning, when initial symptoms are inconclusive, but the member is stable, or when ongoing monitoring is required for post-procedural complications that do not necessitate inpatient care.

Orders for observation or inpatient care must be documented in writing by a physician or authorized hospital staff member as per hospital by-laws. CMS does not endorse using inpatient or observation status for member or physician convenience. Inappropriate use of inpatient status includes situations where members are kept onsite due to socioeconomic factors, for physician convenience in scheduling tests, for routine recovery from ambulatory procedures, or for services routinely performed in outpatient settings, emergency departments or custodial care.

When conducting reviews of inpatient and observation statuses, PCHP applies evidence-based clinical criteria guidelines that adhere to Federal or State regulations and the Hospital or Provider Services Agreement.

The role of observation services is outlined in nationally recognized criteria sets, allowing patients receiving these services to either improve and be discharged or be admitted as inpatients. Guidelines such as InterQual serve as valuable tools for assessing the appropriate use of observation care versus inpatient care. However, it is important to note that guidelines are screening tools and not substitutes for clinical judgment. PCHP's Medical Director reviewers may consider guideline criteria in making determinations but are not bound by any single published criteria. PCHP follows these standards when determining the appropriate payment methodology.

All PCHP healthcare professionals conducting medical necessity reviews require adequate clinical information to make accurate determinations of medical necessity.

If an admission is flagged for reimbursement review, the provider will be asked to provide supporting documentation for the claim submitted, including complete medical charts, itemized bills, and consent forms.

Authorization does not guarantee payment. PCHP reserves the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding and billing practices, and whether the service was provided in the most suitable and cost-effective care setting.

References:

This policy has been developed through consideration of the following:

- CMS, Department of Health and Human Services, Texas Health and Human Services and all applicable agencies, National Correct Coding Initiative.

Policy History:

Description	Date
Policy Created	May 9, 2024
Policy Approved	January 30, 2025