Payment Policy: Short Inpatient Hospital Stay

Reference Number: CC.PP.182
Product Types: Medicaid, Health Insurance Marketplace
Date of Last Revision: 08/2026 Revision Log
Effective Date: 11/01/26

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

Observation services are commonly ordered for patients who present to the emergency department and then require a significant period of treatment or monitoring to make a decision concerning their admission or discharge. The decision of whether to discharge a patient from the hospital following resolution of the reason for the observation care, or to admit the patient as an inpatient, can be made in less than 48 hours and usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than two days.[1,10]

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.

In determining admission status, overall severity and intensity of the services will be considered rather than any 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 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.

When services can be administered in various settings, only those services that are furnished in the most appropriate and cost-effective setting that is appropriate to the member's medical needs and condition will be reimbursed.

Expectation of time and the determination of the underlying need for medical care at the hospital are supported by complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk (probability) of an adverse event occurring during the time period for which hospitalization is considered.[2]

In June 2024, the United States Department of Health and Human Services Office of Inspector General (OIG) published a report stating that Medicare has paid $2.9 billion in fiscal year 2014 for "short inpatient stays that were potentially inappropriate under the two-midnight rule."[3] To curtail inappropriate payments, the OIG recommends that CMS collaborates with its contractors to "implement prepayment edits for claims for short inpatient stays at risk for noncompliance with the two-midnight rule."[3]

Application

This policy applies to inpatient facilities. It does *not* apply to behavioral health admissions or obstetrical delivery admissions.

Reimbursement

Inpatient level of care for hospital stays that do not cross two midnights will be denied reimbursement

unless meeting any of the following:

- Admission is for a procedure on the current CMS Inpatient Only List or is listed as an adult inpatient-only procedure in the InterQual® Setting by CPT® Code Report for members/enrollees age 18 years and over, or is listed as a pediatric inpatient-only procedure in the InterQual® Setting by CPT® Code Report for members/enrollees under 18 years of age
- Admission to an intermediate or intensive care unit level of care (including neonatal intensive care unit [NICU]) is considered medically necessary per a nationally recognized clinical decision support tool in use by the applicable plan
- Admission to acute hospital care at home considered medically necessary per a nationally recognized clinical decision support tool in use by the applicable plan
- Death during the admission
- Departure against medical advice from a medically necessary (per a nationally recognized clinical decision support tool) inpatient stay
- Transferred from another inpatient facility, with a medically necessary (per a nationally recognized clinical decision support tool) total length of stay crossing two midnights or more
- Election of hospice care in lieu of continued treatment in hospital.

Documentation Requirements

The policy's requirements could be enforced in one of the following ways, with associated documentation requirements:

- Concurrent review: Medical records will be used to determine if hospital stays that do not cross two midnights will be reimbursed at the inpatient level of care. If an inpatient claim is denied per the requirements in the Reimbursement section above, providers may follow established appeals processes.
- Pre-payment claims edits: Claims information will be used to determine if an inpatient stay that did not cross two midnights will be reimbursed at the inpatient level of care. If an inpatient claim is denied per the requirements in the Reimbursement section above, the following options are available to providers:
    - Rebilling as observation
    - Disputing the claim denial per established processes
- Post-payment review: The health plan (or designated representative) will request medical records to determine if an inpatient stay that did not cross two midnight met short inpatient hospital stay requirements per the Reimbursement section above. If the inpatient stay did not meet short inpatient hospital stay requirements, the Health Plan may recover the full inpatient payment. The provider may rebill as outpatient, unless expressly prohibited by law from doing so, or as stipulated in the hospital's contract.

References

1. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B (Rev.12421; Issued: 12-21-23 and Rev. 12425; Issued; 12/21/23). https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c06.pdf. Accessed January 14, 2026.
2. Centers for Medicare & Medicaid Services (CMS). Reviewing Short Stay Hospital Claims for Patient Status: Admissions On or After January 1, 2016. (Last Updated: 12/31/2015). https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Reviewing-Short-Stay-Hospital-Claims-for-Patient-Status.pdf. Accessed January 14, 2026.

3. Department of Health and Human Services Office of Inspector General. CMS Could Strengthen Program Safeguards to Prevent and Detect Improper Medicare Payments for Short Inpatient Stays. Report No. A-09-21-03022. Published June 2024. https://oig.hhs.gov/documents/audit/9910/A-09-21-03022.pdf. Accessed January 14, 2026.
4. National Archives. Code of Federal Regulations 42 CFR § 412.3 https://www.ecfr.gov/current/title-42/section-412.3. Accessed January 14, 2026.
5. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A. (Rev. 10892, 08/06/21). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf. Accessed January 14, 2026.
6. Centers for Medicare & Medicaid Services (CMS). Inpatient Only List 2026. https://www.cms.gov/license/ama?file=/files/zip/2026-nfrm-opps-addenda.zip. Accessed January 22, 2026.
7. Centers for Medicare & Medicaid Services (CMS). CY 2024 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1786-FC). Published November 2, 2023. https://www.cms.gov/newsroom/fact-sheets/cy-2024-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0 Accessed January 14, 2026.
8. Centers for Medicare & Medicaid Services (CMS). CMS Manual System Pub 100-20 One-Time Notification. New Occurrence Span Code and Revenue Code for Acute Hospital Care at Home. Published January 20, 2022. https://www.cms.gov/files/document/r11191otn.pdf. Accessed January 14, 2026.
9. Hospital-at-home. American Hospital Association. https://www.aha.org/hospitalathome. Accessed January 14, 2026.
10. Local coverage article: Outpatient Observation Bed/Room Services (L34552). Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/medicare-coverage-database/search.aspx?redirect=Y&from=Overview. Published October 1, 2015 (revised December 19, 2024). Accessed August 28, 2026.

Revision History	
12/2025	Policy created, adapted from CP.MP.182 Short Inpatient Hospital Stay.
02/2026	Annual review. Reimbursement and Policy Overview sections updated with no clinical significance. References reviewed and updated.
05/2026	Added new sections under “Documentation Requirements” related to concurrent review and post-pay review processes.
07/2026	Under “Reimbursement,” changed the requirement for ages 18 years and over for the admission to be on the CMS Inpatient Only List to also include an option for the procedure to be considered inpatient-only per the InterQual® Setting by CPT® Code Report.
08/2026	Noted in the “Application” section that the policy does not apply to BH or OB delivery admissions. Under “Reimbursement: removed BH and OB delivery admissions; added the requirement that acute hospital at home is “considered medically necessary per a nationally recognized clinical decision support tool in use by the applicable plan;” removed “Unexpected” from “Unexpected death during admission.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this

payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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