Policy	MM-0113
Effective Date	**08/01/2026**
Reviewed/Revised Date	08/03/2026
Next Review Date	08/03/2027
Origination Date	08/01/2026
Originated Department	Clinical Operations

Short Inpatient Stay vs. Observation Stay

Audience

Medical Management

Purpose

Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions and must reference the member-specific benefit plan document. The terms of the member-specific Policy document may differ from the standard benefit plan on which this medical policy is based. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the member-specific policy document supersedes this medical policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.

Definition

Short Inpatient Stay refers to an inpatient admission that does not cross two midnights

Observation Services are outpatient hospital services furnished to evaluate, treat, and reassess a patient while determining whether inpatient admission or discharge is appropriate.

Policy/Procedure

Policy/Criteria

Mountain Health Co-Op considers short inpatient hospital stays (vs. observation) spanning less than two midnights not medically necessary.

SECTION I

If an inpatient claim is received that does not cross two midnights and does not meet one of the criteria below, the claim will be denied. Remark **CO-150**

- Unexpected death during the admission (20);
- Departure against medical advice from a medically necessary (per a nationally recognized decision support tool) inpatient stay that was previously authorized (07);
- Election of hospice care in lieu of continued treatment in hospital. (50 or 51)

Appropriate discharge status must be submitted in Box 17 of the claim form.

SECTION II

Mountain Health Co-Op considers inpatient hospital stays on day three (72 hours) and beyond medically necessary when supported by nationally recognized clinical decision support tools.

Inpatient hospital admissions must be authorized. Notification of inpatient admissions must be made by the facility or the member to Mountain Health Co-Op or its medical management delegate on or before two midnights. Failure to notify the health plan of admission may result in denial of the claim. If the facility is in-network, the facility may not hold the member liable for charges. If the facility is out of network, the member may be liable for the total charges of the claim.

This policy does not supersede the need for authorization requirements. Authorization requirements are separate from the determination of medical necessity. Authorization does not guarantee payment, and lack of authorization does not determine by itself whether services are medically necessary unless required under the member's benefit plan. Cases not meeting objective criteria will undergo physician medical director review.

Appropriate claim adjustment reason codes will be applied in accordance with applicable claims processing standards.

Mountain Health Co-Op administers utilization management programs in accordance with applicable federal and state mental health parity requirements. Prior authorization, medical necessity determinations, concurrent review, retrospective review, and documentation requirements for medical/surgical benefits are applied using processes, evidentiary standards, and factors that are comparable to, and no more restrictive than, those applied to mental health and substance use disorder benefits, consistent with applicable law.

Vendors
• Medical Management • Third Party Administrator

Review/Revision/Approval History	
Date	Description
08/01/2026	**New Policy**
08/03/2026	**Reviewed and Approved by the Policy Committee**

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

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