Level of Severity Inpatient Payment Policy	
Policy Type:	New
Applies to:	• Medicare Advantage Products including all Special Needs Plans (SNPs) types (coordinated and integrated D-SNPs, I-SNPs, and C-SNPs) • All participating DRG facilities with a Medicare Allowable/DRG contracting method
Policy Implementation:	Date of Service
Policy Revision Date:	Click Here
Last Review Date:	November, 2025
Next Review Date:	November, 2026

Our payment policies ensure that we pay providers based on the code that most accurately describes the procedure performed. We include CPT/HCPCS, CMS or other coding methodologies in our payment policies when appropriate. Unless noted otherwise, payment policies apply to all professionals who deliver health care services. When developing payment policies, we consider coding methodology, industry-standard payment logic, regulatory requirements, benefits design and other factors.

This Payment Policy expresses Aetna's determination of whether or how certain services or supplies are reimbursed. Payment Policies include references to standard HIPAA compliant code sets to assist with search functions and to facilitate billing and payment for services. New and revised codes are added to the policies as they are updated. When billing, you must use the most appropriate code as of the effective date of the submission. Unlisted, unspecified and nonspecific codes should be avoided when a more specific code exists for the service. ***Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.*** If there is a discrepancy between this payment policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the following website: http://www.cms.hhs.gov/center/coverage.asp. More stringent State requirements may supersede the requirements of this policy.

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Overview

This policy discusses Aetna's level of severity payment policy for Medicare and SNP urgent or emergent inpatient admissions that are one (1) midnight and greater for provider contracts that are paid based on DRG/MDALLW methodologies.

Definitions/Glossary

Term	Definition
DRG	Diagnosis Related Group
MCG	Payment severity guidelines
MDALLW	Medicare Allowable
Lower Level of Severity Rate	Facility specific rate
Higher Level of Severity Rate	Facility inpatient DRG rate

Payment Guidelines

For DRG/Medicare Allowable participating provider contracts, we will authorize urgent or emergent inpatient admissions if the requirements set forth below are met. The level of provider reimbursement will be based on the level of severity. The policy only applies to participating facilities with DRG/MDALLW rate methodology.

For hospital stays where the member stays one (1) midnight and greater, when a Medicare member is urgently or emergently admitted to a hospital and an inpatient order has been submitted by the provider, we will authorize the inpatient admission. Our provider reimbursement guidelines for the authorized inpatient claims will be based on the following criteria:

- For hospital stays where the member stays at least one (1) midnight but less than five (5) midnights, we will perform a level of severity review to determine whether a claim will be paid at the higher or lower level of severity rate:
  - If the inpatient stay meets MCG severity criteria, eligible claims pay at the higher level of severity rate
  - Inpatient stays that do not meet MCG severity criteria will be paid at the lower level of severity rate.
- For hospital stays where the member stays five (5) midnights and greater, we will pay the higher level of severity rate i.e. we will not perform a severity review for hospital stays of five midnights or greater.

Cases involving an unexpected death, CMS inpatient-only procedures, and newly initiated mechanical ventilations will be paid at the higher level of severity rate even if the MCG severity criteria are not met or the length of stay is less than five (5) midnights. Inpatient orders must still be submitted for these cases.

Stays less than one midnight, behavioral health admissions, long-term acute care inpatient admissions, and acute rehabilitation confinements are not subject to the policy and will be reviewed against CMS guidelines.

The payment level (high or low severity) is based on the number of days the member is in the hospital and not on the days authorized.

Time spent in custodial care, delays in care including for procedures, or delays in post-discharge planning shall not be included in the calculation of the length of the member's stay.

Aetna reserves the right to audit approvals to ensure compliance with this policy.

Questions and Answers

Basic Facts

Question	Answer
What is the effective date of the Level of Severity Inpatient Payment Policy?	January 1, 2026.
Does the Level of Severity Inpatient Payment Policy apply to all lines of business?	This policy applies to Medicare and SNP lines of business.
How was this communicated to providers?	The policy was published in the August 2025 OLU. A follow-up communication was published in Availity in November 2025.

Policy Overview

Question	Answer

What will happen starting January 1, 2026 with Medicare Inpatient admissions?	Effective January 1, 2026, we are implementing a new Level of Severity Inpatient Payment Policy for Medicare and SNP inpatient claims.
	
	The policy applies to providers whose contracts are paid based upon DRG/Medicare Allowable. When a Medicare member is urgently or emergently admitted to a hospital and an inpatient order has been submitted by the provider, we will authorize the inpatient stay if the stay is one midnight or greater.
	
	• For hospital stays where the member stays at least one (1) midnight but less than five (5) midnights, we will perform a level of severity review to determine whether a claim will be paid at the higher or lower level of severity rate:
	  ○ If the inpatient stay meets MCG severity criteria, eligible claims pay at the higher level of severity rate
	  ○ Inpatient stays that do not meet MCG severity criteria will be paid at the lower level of severity rate.
	• For hospital stays where the member stays five (5) midnights and greater, we will pay the higher level of severity rate i.e. we will not perform a severity review for hospital stays of five midnights or greater.
	
	Under the payment policy, the MCG criteria will not be used to determine whether an inpatient stay is medically necessary. Instead, MCG criteria will be used to determine the severity of an inpatient admission. Depending on the severity, we will pay either the higher level of severity rate or the lower level of severity rate.
	
	Providers have the option to request a review of the severity determination (including the right to have a severity discussion with an Aetna medical director) and to appeal for the inpatient rate, if they believe the stay meets the MCG severity criteria.
	
	Cases involving an unexpected death, CMS inpatient-only procedures, and newly initiated mechanical ventilations will be paid at

	the higher level of severity rate even if MCG severity criteria are not met or member's stay is less than 5 midnights. Inpatient orders must still be submitted in these cases. Stays that are less than one midnight, behavioral health admissions, long-term acute care inpatient admissions, and acute rehabilitation confinements are not subject to the policy and will be reviewed against CMS guidelines.
Is Aetna's Level of Severity Inpatient Payment Policy in compliance with the Medicare Advantage Two Midnight Rule?	Our Level of Severity Inpatient Payment Policy complies with the Two Midnight Rule. For providers whose contracts are paid based upon a DRG/Medicare Allowable methodology, all urgent or emergent inpatient admission requests, with inpatient orders, will be authorized as inpatient stays for stays one midnight or greater for Medicare and SNP members. We will not deny any inpatient admission request that is subject to the policy. The Two Midnight Rule is a coverage rule and is used to assess whether a stay is medically necessary. The policy complies with the Two Midnight Rule as we are approving the inpatient stays. While CMS regulates inpatient coverage determinations, it does not dictate payment terms for contracted providers. The policy is a claims payment policy that determines reimbursement based on the severity level of the inpatient admission.
How does this policy benefit providers?	Over the years, hospitals across our networks have requested that, upon denial of an inpatient admission for not meeting the inpatient coverage criteria, we pay them a rate akin to the observation rate, instead of requiring them to re-bill the denied claim as an observation stay. We heard our providers' concerns. In response, our new policy will pay participating providers even for claims that, in the past, were denied for not meeting inpatient criteria – claims for which no reimbursement was paid. For urgent or emergent hospital stays where the member stays at least one (1) midnight but less than five (5) midnights, inpatient stays that meet the MCG severity criteria will continue to be paid at the higher level of severity rate and treated as they are today. Inpatient stays that do not meet the MCG severity criteria will also be authorized as inpatient but will be paid at a rate that reflects a lower severity hospitalization. The lower level of severity rate is comparable to the observation rate. Hospital stays that cross five (5) midnights or greater will not be subject to the severity review and claims will be paid at the higher severity rate (inpatient DRG rate). Besides providing for a speedy payment, the policy also offers providers additional review rights. • First, providers will be notified whenever we intend to reimburse an inpatient stay at a lower level of severity rate. Providers that disagree with this rate may request a severity review with additional medical records. Providers may also ask to have a severity discussion with an Aetna medical director. • Second, after a claim is adjudicated, providers have the opportunity to appeal a lower level of severity payment as they would any contractual payment dispute.

Can Aetna introduce a policy that changes a hospital's reimbursement?	Under the provider's contract, Aetna is permitted to introduce and implement payment policies. Providers agree to comply with policies that Aetna may implement from time to time.
How are stays of less than one midnight handled?	Stays less than one midnight will be approved as inpatient admissions if they meet CMS guidelines. Note: Stays less than one midnight are not subject to the Level of Severity Inpatient Payment Policy.
How is this policy different from the current practice?	Currently, inpatient admissions that do not meet the inpatient coverage criteria are denied, with no payment to the Provider. • This means that the provider has to re-bill the claim as an outpatient observation or appeal the denied inpatient stay. • Under the new policy, the inpatient stay will be authorized and if the stay does not meet the MCG criteria for severity, Aetna will reimburse the claim at the lower level of severity rate where the member stays at least one (1) midnight but less than five (5) midnights. For hospital stays of five (5) midnights or greater, the inpatient stay will be authorized, and the claim will be paid at the higher level of severity rate without a severity review.

Clinical Workflows

Question	Answer
Is a peer-to-peer meeting available under this policy?	Today, a peer-to-peer is available if an inpatient authorization request is denied. Under the new policy, there is no inpatient authorization denial that would trigger a "peer to peer". However, we will offer providers the opportunity to request a discussion with a medical director, should the provider disagree with a lower level of severity determination. Providers requesting a severity discussion can call 1-888-422- 4817 (Medicare) and 1-855-711-3801 (SNP) to request the severity discussion with the Medical Director.
When can a provider request a severity discussion?	For hospital stays where the member stays at least one (1) midnight but less than five (5) midnights where the lower level of severity has been applied, providers have up to 14 calendar days from the date of the severity decision notification and before the claim is submitted to request a severity discussion with the Medical Director. Please notify Aetna if an admission originally deemed as a lower level of severity case has crossed the 5th midnight, so we can update the severity determination.
What are the criteria in which providers can request a severity review of the case and engage in a severity discussion with our medical directors?	Providers may request a severity review and engage in a severity discussion with an Aetna medical director for lower level of severity cases for inpatient stays that are at least one (1) midnight but less than five (5) midnights. If an inpatient stay crosses five (5) midnights or greater, it will be upgraded to a higher level of severity rate, and a review or a severity discussion would no longer be required.
Will the provider need to submit an authorization for the inpatient admission?	The new policy does not change the current requirement to submit a request for an inpatient authorization. The existing process should be followed.
When does a provider need to submit clinical documentation?	• Providers must notify us of an inpatient admission within 2 business days of the admission.

	• Clinical information (medical records and an inpatient order) must be submitted with the original request or within 24 hours of the notification.
Will providers be notified of our decision after the clinical review for severity?	We perform an initial severity review when the inpatient admission request is received and authorized. The payment level (high or low level of severity) is based on the number of days the member is in the hospital and not on the days authorized. The provider will receive a written notification of the inpatient authorization and severity decision. The decision letter will include one of the following based on level of severity: **Meets MCG Severity Criteria (High Severity)** • We will approve the inpatient stay for 7 days (Medicare) or 10 days (SNP). **Does not meet MCG Severity Criteria (Low Severity)** • We will approve the inpatient stay for 7 days (Medicare) or 10 days (SNP). • Additionally, the provider letter will include the following: *We've authorized your inpatient stay. We've reviewed your case and it's approved to be paid at the lower level of severity rate.* *If you disagree with this severity determination, you may request, via fax, that we review the case with any additional clinical information that you provide. This request must be received within **7 business days from date of decision notification** and before the claim is submitted. If additional clinical is submitted, please clearly mark that it is a request for an updated severity review. You'll receive this decision through the mail or through Availity. You may also request a severity discussion with a Medical Director. This request must be received within **14 calendar days from the date of the decision notification** and before the claim has been submitted. Please note that, if a severity discussion has taken place, there will be no further opportunity to request a review of the case prior to the claim payment. After the claim is paid, you retain your contractual rights to dispute the level of payment. You'll receive this decision through the mail or through Availity.*

Operational and Administrative

Question	Answer
How will claims with the lower level of severity payment be identified in the: • **Member Explanation of Benefits (EOB),** • **Explanation of Provider Payment (EOPP), and the** • **Electronic Remittance Advice (ERA)?**	The following messages will be in the EOBs and ERA: **Member (EOB) Wording:** We have approved your inpatient stay. You don't have a next step at this time. [AHA5] **Provider (EOPP) Wording:** We've determined that this inpatient stay did not meet the clinical severity criteria. The allowed amount was reduced to a lower level of severity payment. [AHA5] **ERA/835 Wording:** Alert: Payment based on an appropriate level of care. [N610]

	• Providers should look for the following mapping within the ERA to identify paid claims at the lower level of severity payment: o Provider assigned and billed inpatient "Type of Bill code (11x)", and o N610 is applied, and o Medicare or Duals claim

Appeals and Disputes

Question	Answer
For hospital stays of at least one (1) midnight but less than five (5) midnights, can providers dispute a lower level of severity rate/decision?	Yes, providers maintain the right to dispute the lower level of severity rate and/or appeal for the higher level of severity rate if they believe the stay meets the MCG severity criteria. Providers must articulate clear rationale for the dispute and submit applicable clinical documentation with their submission.
What is the process to follow for a payment policy dispute?	Providers can utilize the existing disputes and appeals submission process outlined on our aetna.com website. Link: Disputes & Appeals Overview | Aetna After the claim is adjudicated, the provider remit will have the following language: *If you are a contracted provider and disagree with our decision, you can dispute using the information provided below: Mail the appeal request to: Medicare Provider Appeals P.O. Box 14835 Lexington, KY 40512 Or fax# 860-900-7995*

Additional References

Medicare Program Integrity

Policy Revision Date

N/A