Inpatient Authorizations and Concurrent Review Guide

Includes Sepsis-Specific Claims Review Requirements
Applies to admission dates on or after October 1, 2026
Last revised: November 2026

Purpose

This guide explains CareOregon's authorization and concurrent-review process for inpatient admissions. It describes how admissions are authorized, how continued stays are reviewed for medical necessity throughout the inpatient stay, and the additional claims-review requirements that apply to short inpatient stays for the treatment of sepsis. It also covers claim outcomes, appeals, and supporting definitions and references.

Scope

This guide applies to inpatient admissions under CareOregon medical benefit plans. It explains CareOregon's authorization and concurrent-review process for inpatient admissions, including the additional claims-review requirements for short inpatient stays for the treatment of sepsis.

- Provider or facility types: Providers, non-physician providers, subcontractors, and facilities that request authorization for inpatient admissions or submit inpatient facility claims
- Claims affected: Inpatient admissions and inpatient facility claims
- Effective for admission dates on or after: October 1, 2026

Background

OIG began scrutinizing sepsis DRG billing in 2018. By FY 2019, sepsis (DRG 871) had become the most frequently billed MS-DRG nationally. This growth was driven in part by a 2016 change in the clinical definition of sepsis: CMS and CDC still use an older, broader definition, while the newer Sepsis-3 standard is narrower. In March 2024, OIG announced a nationwide audit of 2023 Medicare sepsis claims (see References). CareOregon's internal audits of 2023–2024 sepsis inpatient stays surfaced similar concerns, which led to this shift to concurrent review for inpatient admissions, described below.

Policy

CareOregon uses a concurrent-review process for inpatient admissions. Concurrent review is a utilization management process that is separate from claims processing.

1. Admission — standard authorization. The facility submits an authorization request for the inpatient admission. The request is reviewed and approved or denied under usual authorization processes and criteria.
2. Concurrent review. Following authorization, the admission is monitored through medical record documentation throughout the inpatient stay. Continued hospitalization is approved or denied based on medical necessity.

For admissions involving the treatment of sepsis, CareOregon applies InterQual® Level of Care: Acute Adult criteria (current release), including the Infection: Sepsis subset and any other subset that applies to the condition treated, during both authorization and concurrent review.

This review does not dispute the sepsis diagnosis or the treatment provided. It determines whether the medical record supports the inpatient level of care.

Sepsis-specific review criteria

In addition to concurrent review, CareOregon pends inpatient facility claims for stays involving the treatment of sepsis for Payment Integrity review when the length of stay is less than 3 days.

Authorization outcomes

Review finding	Outcome
Inpatient stay determined medically necessary	Authorization is approved.
Inpatient stay determined not medically necessary	Authorization is denied.
Observation	Observation stays may be approved when medical necessity is met while medical necessity for inpatient is not.

Reconsideration and appeals

Appeals may be submitted, with supporting documentation, to the Provider appeals/reconsiderations section of the Connect Portal through the “Submit Claim Attachments” feature.

Definitions

OIG: Office of Inspector General

DRG: Diagnosis Related Group

UM: Utilization Management

Concurrent review: Review of an inpatient admission during the stay to determine whether continued hospitalization is medically necessary

InterQual®: Evidence-based clinical decision support criteria used to determine medical necessity for a level of care

These guidelines have been developed to accompany and complement the official conventions and instructions provided within the American Medical Association’s Current Procedural Terminology (CPT®) itself. Additions and deletions conform it to the most recent publications of CPT® and HCPCS Level II and to changes in CareOregon and its affiliates coverage policy and payment status, and as such these guidelines are current as of the applicability date above. Every reasonable effort has

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References

Centers for Medicare & Medicaid Services (CMS)

ICD-10-CM Official Guidelines for Coding and Reporting FY 2027 (October 1, 2026)

U.S. Department of Health and Human Services, Office of Inspector General (OIG)

OIG Work Plan: Medicare Inpatient Hospital Billing for Sepsis

Association of Clinical Documentation Integrity Specialists (ACDIS)

ACDIS News: OIG to Review Medicare Inpatient Hospital Billing for Sepsis

JAMA

The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3), JAMA 2016

InterQual®

InterQual® Level of Care: Acute Adult criteria, Infection: Sepsis subset (current release)