Inpatient Coverage Guidelines

Medicare Advantage Medical Policy No: MNG-002
Original Effective Date: 12/27/2023
Current Effective Date: 01/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Policy Guidelines

Inpatient Coverage Guidelines Instructions for Use

Hospital services for inpatient levels of care are covered when criteria for admission are met. All inpatient services must be reasonable and necessary to be covered by the MA plan. Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they relate to the member's clinical circumstances.

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark and the medical record must supports that reasonable expectation. Admissions are not covered or noncovered solely based on the length of time the patient actually spends in the hospital. A hospital stay that spans two midnights without sufficient severity of illness and or appropriate intensity of service may not be covered.

The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs. The doctor must write an order to admit to inpatient and the hospital must formally admit the patient in order for inpatient services to be covered.

For coverage to be appropriate under Medicare for an inpatient admission, the patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient.
- The medical predictability of an adverse event.

We reserve the right to use the prior authorization or concurrent case management review of inpatient admissions based on whether the complex medical factors documented in the medical record support medical necessity of the inpatient admission, under either the two-midnight benchmark or the case-by-case exception.

Additional Considerations/ Policy Exceptions

Inpatient only: The Social Security Act allows CMS to define services that are appropriate for payment under the Outpatient Prospective Payment System (OPPS). Inpatient admissions where a medically necessary inpatient-only procedure is performed are generally appropriate for Medicare Part A payment regardless of expected or actual length of stay. Under this authority, CMS also identifies services that should be performed in the inpatient setting. These services are itemized on the inpatient list, also known as the inpatient-only list. For inpatient only, reference CMS Addendum E. - Final HCPCS Codes that Would Be Paid Only as Inpatient Procedures. MM13784 - Hospital Outpatient Prospective Payment System: (cms.gov)

Inpatient Order: A Medicare beneficiary is considered an inpatient of a hospital if formally admitted as an inpatient pursuant to an order for inpatient admission by an ordering practitioner. As stated in the FY 2014 IPPS Final Rule, 78 FR 50908 and 50941, and as conveyed in 42 CFR 482.24, if the order is not properly documented in the medical record prior to discharge, the hospital should not submit a claim for Part A payment. Meeting the two-midnight benchmark does not, in itself, render a beneficiary an inpatient or serve to qualify them for payment under Part A. Rather, as provided in Medicare regulations, a beneficiary is considered an inpatient (and Part A payment may only be made) if they are formally admitted as such pursuant to an order for inpatient admission by a physician or other required practitioner.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References

1. (n.d.). Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A. Https://www.cms.gov/Regulations-And-Guidance/Guidance/Manuals/Downloads/Bp102c01.pdf.

2. (n.d.). Quality Improvement Organization Manual, Chapter 4, §4110 – Admission/Discharge Review. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/qio110c04.pdf.
3. (n.d.). InterQual Solution. https://www.changehealthcare.com/clinical-decisionsupport/interqual.
4. (n.d.). Final Rule 2024. https://public-inspection.federalregister.gov/2023-07115.pdf.
5. (n.d.). Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. https://www.Federalregister.gov/Documents/2023/04/12/2023-07115/Medicare-Program-Contract-Year-2024-Policy-And-Technical-Changes-To-The-Medicare-Advantage-Program.
6. (n.d.). CMS Addendum E. https://www.cms.gov/Files/Document/Mm13031-HospitalOutpatient-Prospective-Payment-System-January-2023-Update.pdf.

Policy History

Original Effective Date: 12/27/2023
Current Effective Date: 01/01/2025
12/23/2023 New policy created.
12/27/2023 Utilization Management Committee review and approval. New Policy.
10/15/2024 Policy reviewed and revised.
10/15/2024 Utilization Management Committee review and approval. Reference sources updated. No substantive changes made.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®

Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review nurse does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.