# Medical Policy
# Acute Inpatient

**Policy Number:** 04

| | Commercial and Qualified Health Plans | MassHealth |
|---|---|---|
| Authorization required<br>• Elective inpatient hospital admissions<br>• Concurrent days of care following authorization or notification | X | X |
| Notification within 24 hours or the next business day<br>• Emergent, urgent, and obstetrical inpatient admissions<br>• Sick Newborns | X | X |
| No Prior Authorization | | |

**Overview**
The purpose of this document is to describe the guidelines Mass General Brigham Health Plan utilizes to determine medical appropriateness used in authorizing acute inpatient hospital stays/days.

**Coverage Guidelines**
Mass General Brigham Health Plan covers acute inpatient hospitalizations. Mass General Brigham Health Plan requires that all elective inpatient hospital admissions must have a prior authorization at least five business days before the admission date which will be reviewed as expeditiously as possible but may take up to fourteen days to complete the review. Emergent, urgent, and obstetrical inpatient hospital admissions do not require prior authorization but do require notification within twenty-four hours or by the next business day as a condition for payment. Newborns emergently transferred to another acute care facility or to a NICU in the same facility also require notification within twenty-four hours or by the next business day as a condition for payment. Failure to obtain the required prior authorization or to provide the required notification may result in an administrative denial of payment to the facility.

Authorization review determinations are made in accordance with relevant Mass General Brigham Health Plan policies and procedures which seek to ensure that utilization decisions are made in a fair, impartial, and consistent manner.

**Acute Inpatient Level of Care**
Mass General Brigham Health Plan covers medically-necessary acute inpatient level of care for adult and pediatric when the services meet accepted standards of InterQual® Acute Level of Care Criteria. Acute criteria address observation and inpatient level of care for specific and general, medical, and surgical conditions. In order to make a medical necessity determination, Mass General Brigham Health Plan requires certain documentation to be provided, including but not limited to: emergency room note, admission notes, admission orders, pertinent labs, and consults. For ongoing care and a continued stay, Mass General Brigham Health Plan also requires submission of pertinent clinical notes and treatment plans and medication sheets.

Medical necessity for acute inpatient levels of care are established for commercial /qualified health plan members in the following instances:

- When acute level of care hospital services are medically necessary in accordance with InterQual® criteria.

Medical necessity for acute inpatient levels of care are established for MassHealth members in the following instances:

- When acute level of care hospital services are medically necessary in accordance with InterQual® criteria.
- Mass General Brigham Health Plan covers administratively necessary days if the member's care can be provided in a setting other than an acute inpatient hospital and the member is clinically ready for discharge, but an appropriate setting is not available.

**Note:** Mass General Brigham Health Plan makes available to members, prospective members and providers licensed proprietary criteria only to the extent which is relevant to a particular treatment or service identified by the member, prospective member, or provider.

**Exclusions**

Mass General Brigham Health Plan does not cover acute inpatient stays/days for the treatments that do not meet the criteria noted above. In addition, Mass General Brigham Health Plan does not provide coverage for acute inpatient level of care stays/days when:

1. An inpatient procedure has been delayed due to cancellations, scheduling conflicts, oversights, malfunctioning equipment, delayed test results, or consultations.
2. Mass General Brigham Health Plan determines that appropriate placement or services are available within a reasonable distance of the member's usual residence, but the hospital or physician refuses or neglects to discharge the member.
3. An appropriate placement or service is currently available, but the hospital has not transferred or discharged the member due to the hospital's administrative or operational delays.
4. Mass General Brigham Health Plan determines that appropriate placement or services are available within a reasonable distance of the member's usual residence, but the member, member's family, or legal guardian refuses the placement or services.
5. Pre-operative/procedure admission days or discharge delays occur that are solely for the convenience of the member and/or family.
6. The hospital care management and physician do not provide timely clinical information in which to make an admission or continued stay decision, which will result in administrative denial of payment.
7. The explicit and sole purpose for the acute inpatient level of care is to render experimental treatment unless one of the qualifying factors applies**:**
    I. A bone marrow transplant or transplants for members who have been diagnosed with breast cancer that has progressed to metastatic disease, provided that the member meets the criteria established by the Department of Public Health as listed in M.G.L Chapter 176G: Section 4F
    II. Medically necessary services associated with the administration of off-labeled drugs for HIV/AIDS and cancer treatment when the off-label use of the drug has not been approved by the federal Food and Drug Administration for that indication, if such drug is recognized for treatment of such indication in one of the standard reference compendia, in the medical literature, or by the Commissioner under the provisions of section forty-seven of chapter 175 of the M.G.L
    III. Coverage for a member enrolled in an approved clinical trial as per Public Law 111 - 148 - Patient Protection and Affordable Care Act, Section 2709
8. A preventable Serious Reportable Event (SRE) has occurred and the event results in additional inpatient days that would not have otherwise been necessary.

**Definitions**

Concurrent Review**:** Any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments; concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

Notification: The process by which Mass General Brigham Health Plan is informed of the delivery of specific services. Notification is a requirement for reimbursement of specific services under Mass General Brigham Health Plan's Utilization Management program.

Prior Authorization: Any case or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services; preauthorization and precertification are pre-service decisions.

Serious Reportable Events: An event that occurs on the premises of a provider's site that results in an adverse patient outcome; is clearly identifiable and measurable; usually or reasonably preventable; and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider or facility. An SRE is an event that is designated as such by the Department of Public Health (DPH) and identified by EOHHS. Mass General Brigham Health Plan utilizes the National Quality Forum's (NQF) definition of SREs.

**Related Policies**

- Ambulatory Surgical Centers Provider Payment Guideline
- Obstetrical Services-Professional Provider Payment Guideline

**Effective**

June 2022: Annual update.
May 2021: Annual update. Changes in language on page 1. Under Acute Inpatient Level of Care Subheading:

- Added "for adult and pediatric" to first sentence
- Removed sentence "Pediatric criteria also address the nursery levels of care

May 2020: Annual update. Revisions made to table on page 1.
August 2019: Annual update. Changes in language regarding inpatient level of care. References updated.
November 2018: Annual update.
February 2017: Annual update.
February 2016: Annual update.
February 2015: Annual update, no significant changes.
February 2014: Annual update reorganized.
August 2012: Annual update, no significant changes.
September 2011: Annual update.
September 2010: Annual update.
September 2009: Annual update.
September 2008: update.
January 2008: Annual update.
January 2007: Annual update.
April 2006: Annual update.
April 2005: Annual update.
October 2003: Effective date.

**References**

Commonwealth of Massachusetts Division of Medical Assistance Acute Inpatient Hospital Manual

MassHealth ACO Contract §2.6D

Change Healthcare LLC , InterQual ®level of care criteria, Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub acute and Skilled Nursing Facilities Adult and Pediatric.

Massachusetts Code of Regulations 105 Department of Public Health Subpart C 130.332

General Laws of Massachusetts Chapter 176G: Section 4F. Group health maintenance contracts; coverage for bone marrow transplants https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176g

General Laws of Massachusetts Chapter 176G: Section 4G. Off-label use of prescription drugs for HIV/AIDS treatment https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176G/Section4G

General Laws of Massachusetts Chapter 175: Section 47O. HIV/AIDS treatment; insurance coverage for certain off-label use of prescription drugs
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47O

General Laws of Massachusetts Chapter 176G: Section 4E. Off-label drug use; cancer treatment Division of Medical Assistance 130 CMR 450.000: 450.231: General Conditions of Payments (**D) A Provider is responsible for verifying a Member's eligibility status on a daily basis, including but not limited to Members who are hospitalized or institutionalized.** In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the Provider must comply with any service authorization requirements and all other conditions of payment. A Provider's failure to verify a Member's MassHealth status before providing services to the Member may result in nonpayment of such services. For payment for services provided before a Member's MassHealth eligibility determination, see 130 CMR 450.311.

Public Law 111 - 148 - Patient Protection and Affordable Care Act Section 2709