Medical Policy
Acute Inpatient

Policy Number: 04

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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.

Medicare Advantage
Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for its Medicare Advantage plan members. Consistent with CMS regulations described in 42 CFR 412.3 and the 2014 Hospital Inpatient Prospective System Final Rule, and the 2024 Medicare Advantage Final Rule, and as explained in the CMS publication “Fact Sheet: Two-Midnight Rule,” Mass General Brigham Health Plan applies the 2-midnight benchmark and the Hospital Outpatient Prospective Payment System (OPPS) Inpatient Only List to determine whether acute inpatient hospital care is medically necessary for Medicare Advantage members. According to these rules, acute inpatient hospital care is medically necessary when a member:
- undergoes a procedure on the OPPS Inpatient Only List, OR
- requires newly initiated mechanical ventilation, OR
- receives medically necessary care that is reasonably expected to require at least 2 midnights in the hospital, exclusive of delays in care

Mass General Brigham Health Plan uses InterQual criteria to determine what constitutes “medically necessary care” in the definition above. Services that meet InterQual criteria for observation, acute, intermediate, or critical level of care are considered medically necessary when applying the 2-midnight benchmark. When a patient is admitted for medically necessary care that is reasonably expected to require ≥2 midnights in the hospital but the actual duration of care is shorter because of unforeseen circumstances (such as unexpected death, unexpected transfer, unexpectedly rapid improvement, or departure against medical advice), inpatient care is authorized.

Acute inpatient care is not considered medically necessary when a member:
- receives hospital care for exclusively social reasons or convenience (i.e., care that does not meet InterQual criteria at the observation level or higher), regardless of the duration of care
- receives medically necessary care that is reasonably expected to require <2 midnights in the hospital,
- receives medically necessary care that is reasonably expected to require ≥2 midnights in the hospital only because of a delay in care

According to the CMS Fact Sheet, a rare exception to the 2-midnight benchmark is permitted “for stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception) . . . on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.”¹ Mass General Brigham Health Plan may grant such case-by-case exceptions when a Medical Director determines that the need for inpatient care lasting <2 midnights is both medically reasonable and appropriately documented by the attending physician.

For further details on how Mass General Brigham Health Plan applies InterQual criteria in the context of the 2-midnight benchmark, see the note “2MN” within the InterQual Acute LOC subsets.

**Coverage Guidelines: Commercial and ACO plans**

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.

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:

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¹ An example that may warrant inpatient care under this “case-by-case exception” despite a brief anticipated length of stay is acute coronary syndrome requiring heparinization while awaiting transfer on the second hospital day to another facility for percutaneous intervention.
• 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: Commercial and ACO plans**
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 2024: Annual update. Medicare Advantage section added.
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
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
Centers for Medicare & Medicaid Services. (2014). Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2015 Rates; Quality Reporting Requirements for Specific Providers; Reasonable Compensation Equivalents for Physician Services in Excluded Hospitals and Certain Teaching Hospitals; Provider Administrative Appeals and Judicial Review; Enforcement Provisions for Organ Transplant Centers; and Electronic Health Record (EHR) Incentive Program. Final rule. Federal Register, 79(160), 49853-50536.


Commonwealth of Massachusetts Division of Medical Assistance Acute Inpatient Hospital Manual

EOHHS ACPP Contract

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.

Commonwealth of Massachusetts, Department of Public Health, Agency Manual. Hospital License (105 CMR 130.000)

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

42 C.F.R. § 412.3