Inpatient Hospital Admissions for Review

According to Medicare rules, a service must be medically necessary to be covered. Medical necessity decisions are made on the clinical information provided to us by your physician and the Medicare Benefit Policy Manual, Chapter 1, Section 10, which states:

Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.

However, 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 types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. 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 something adverse happening to the patient.

• The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

• The availability of diagnostic procedures at the time when and at the location where the patient presents.

For Medicare basic benefits, Medicare Advantage (MA) organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined in the Medicare Code of Federal Regulations § 422.101(c)1; based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in Medicare Code of Federal Regulations § 422.101(b)(6).

Additionally, Highmark Wholecare may use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. You may review the InterQual® criteria here