



Acute Inpatient Hospital Admission Clinical Coverage Criteria

Overview

The purpose of this policy is to provide an overview of how Fallon Health Utilization Management department authorizes and ensures medical necessity criteria for inpatient level of care are met, based on applicable coverage criteria, medical records, and physician judgment.

Regulatory Reference(s)

Medical necessity determinations are based on regulatory requirements outlined in:

- Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A CMS Medicare criteria (MAPD, DSNP and Pace)
- Medicare Inpatient-Only (IPO) list (MAPD, DSNP and PACE)
- Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Chapter 13
- 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)
- 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)
- 2026 Medicare Advantage and Part D Final Rule (CMS-4208-F)
- Medicare Members Evidence of Coverage
- PART 460—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
- MassHealth/Medicaid criteria (for all other products)

Policy

This Policy applies to the following Fallon Health products:

- ☒ Fallon Medicare Plus
- ☒ MassHealth ACO
- ☒ NaviCare HMO SNP
- ☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
- ☒ Community Care

Authorization requirements

- Prior authorization required for elective admissions
- Notification required for emergent admissions
- Continued stay authorization required

Fallon Health Clinical Coverage Criteria

Medical Necessity Criteria by Line of Business

1. Fallon Medicare Plus, NaviCare, and PACE

Inpatient admission is medically necessary when:

- The admitting physician expects the member to require hospital care spanning at least two midnights, supported by documentation of:
 - Severity of illness
 - Comorbidities
 - Clinical risk and need for hospital-level services

OR

- The admission qualifies under:
 - Case-by-case exception
 - Medicare Inpatient-Only procedures

Two Midnight Rule - When a member arrives at a hospital in need of medical or surgical care, the physician, or other qualified practitioner must decide whether to admit the beneficiary as an inpatient or treat him or her as an outpatient. Additionally, if clinical circumstances warrant, a physician may admit as inpatient a beneficiary initially hospitalized as an outpatient during the hospitalization. Not all care provided in a hospital setting is appropriate for inpatient stays.

For stays expected to last less than two midnights – CMS adopted the following policies that must be followed and inpatient stays must be authorized:

- For medically necessary hospital stays that are expected to be two midnights or longer, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient will stay at least two midnights. This includes stays in which the physician's expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, rapid clinical improvement, or departure against medical advice
- 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), the hospital physician on a case-by-case basis based on the judgment of the admitting physician may decide to admit the member. The documentation in the medical record must support that an inpatient admission is necessary and is subject to medical review.

Key requirement - The expectation and supporting clinical factors must be clearly documented in the medical record. The statement of a physician expecting a hospitalization of greater than two midnights is not sufficient – the medical record must support that the member's medical condition, safety, or health would be significantly and directly threatened if care was provided in any less intensive setting. If the medical record and the member's medical care and condition do not support the physician's expectation, Fallon Health may issue an adverse determination after appropriate Medical Director or delegated business associate review.

2. MassHealth ACO and Community Care

Inpatient admission is medically necessary only when:

- The member cannot be safely or effectively treated at a lower level of care, including observation or outpatient care; and
- A lower-cost, less intensive setting would not meet clinical needs or would pose risk to the member's health or safety

Key principle - If InterQual guidelines and clinical review support that care can be safely delivered at a lower level of care, inpatient admission is not medically necessary.

Use of InterQual Criteria (All Lines of Business*)

InterQual criteria are not used as the sole basis for coverage decisions, are applied as a supporting clinical framework to:

- Evaluate whether clinical findings support inpatient vs. alternative levels of care
- Identify when observation or outpatient care is clinically appropriate
- Provide structured clinical evidence regarding severity, services, and expected course of care

For denial and level-of-care determinations:

InterQual findings may be cited to support that inpatient criteria are not met, including:

- Insufficient severity of illness
- Lack of intensity of services requiring inpatient care
- Availability of safe and appropriate lower levels of care

Denial rationales will:

- Clearly reference the applicable governing standard (Medicare or Medicaid)
- Use InterQual criteria as supporting clinical evidence, not as the sole basis for denial

This approach ensures:

- Compliance with CMS requirements prohibiting exclusive reliance on proprietary criteria
- Alignment with MassHealth expectations regarding level-of-care appropriateness
- Consistency and defensibility of medical necessity determinations

* For Fallon Medicare Plus and NaviCare, InterQual may only be used if there are no CMS NCD, LCD, Chapter, or other regulatory coverage criteria, or if such criteria are not fully developed. Also, InterQual includes within the program CMS's NCD, LCD and Chapter guidance thus it is critical to document the CMS criteria, not that an InterQual policy was utilized. The InterQual policies that are separate and distinct would be documented when utilized with CMS criteria or in the absence of such guidance.

Elective Admissions

- All elective admissions require prior authorization
- The CMS Inpatient Only List is used for all lines of business. The "Inpatient-Only" procedure list is updated annually and published in the Hospital Outpatient Prospective Payment System (OPPS) Final Rule available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices>.
- Medicare NCDs and LCDs are used for Medicare, NaviCare and PACE
- MassHealth criteria are used for Medicaid and Community Care
- When there are no Medicare or MassHealth criteria, plan developed criteria may be used

Concurrent Review*

- Continued stay requests are reviewed using clinical documentation
- If inpatient criteria are not met:
 - An adverse determination will be issued
 - Observation or alternative level of care may be offered
- Providers may withdraw inpatient requests and accept a lower level of care

* For the Medicare and NaviCare product lines, CMS now defines concurrent review as an organization determination. Therefore, for each concurrent review the appropriate approval or denial notification must be sent.

Clinical Documentation Requirements (Medical Records)

The members' medical records must support:

- Severity of illness
- Intensity of services
- Need for inpatient level of care
- Physician recommendations as to why the admission is required (for Medicare lines)
- The physician orders

General Criteria

Across all products:

- Services must be medically necessary and non-investigational or experimental
- Determinations are based on clinical documentation and applicable coverage criteria as noted above
- InterQual is used to support, not replace, governing criteria

Medicare Advantage and NaviCare

Medicare Advantage determinations must first follow applicable Medicare statutes, regulations, National Coverage Determinations, Local Coverage Determinations, and Traditional Medicare coverage and benefit conditions before any internal, plan developed, or proprietary criteria are used. This is tied to the requirements under 42 CFR § 422.101.

InterQual or other internal criteria may only be used when Medicare coverage criteria are not fully established and only if the criteria meet CMS requirements for public accessibility and evidentiary support under 42 CFR § 422.101(b)(6)

If Fallon uses internal or plan developed criteria for Medicare Advantage decisions, the policy should include the requirement that the criteria, evidence summary, source list, and rationale be publicly accessible. This is a CMS requirement under 42 CFR § 422.101(b)(6).

All Medicare Advantage medical necessity determinations shall be based on the enrollee's individual clinical circumstances, including diagnoses, functional status, comorbidities, current medical needs, risk of adverse event, treating provider documentation, and clinical notes. Determinations shall not rely solely on screening criteria, proprietary criteria, algorithms, or generalized clinical guidelines.

Utilization Management staff shall consider the attending physician's documentation, treatment plan, clinical judgment, and rationale for inpatient level of care as part of each Medicare Advantage medical necessity determination.

Adverse medical necessity determinations shall include Medical Director or appropriately qualified physician review consistent with applicable CMS requirements. Fallon retains ultimate responsibility for the clinical accuracy of organization determinations and reconsiderations involving medical necessity, including when review activities are delegated.

All organization determination requirements, including applicable notice requirements, denial content, appeal rights, and required timeframes under 42 CFR § 422.568 must be met.

Services subject to prior authorization, standard organization determinations must be made as expeditiously as the enrollee's health condition requires and no later than the applicable timeframe under 42 CFR § 422.568. The policy should also address extensions when permitted and the requirement to provide written notice when a service is denied, reduced, or prematurely discontinued.

Requests that meet criteria for expedited review shall be processed in accordance with the Plan's Medicare Advantage organization determination and appeals policy, including applicable expedited timeframe, notice, and appeal requirements under 42 CFR § 422.570 and 42 CFR § 422.572.

Medicare Variation

N/A

MassHealth Variation

N/A

Exclusions

N/A

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

Coding

N/A

References

N/A

Policy history

Origination date: 12/01/2026

Review/Approval(s): Technology Assessment Committee: N/A

Utilization Management Committee: 08/18/2026 (policy origination; approved).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.