

# SMSO Policy Manual

## Acute Inpatient Hospital Stay Policy

Executive Sponsor: Chief Medical Officer

Issuing Department: Clinical Management

Gate Keeper: Director, HSM Clinical Management

### **COMPLIANCE STATEMENT:**

**Enforcement:** All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

**Review Schedule:** This policy will be reviewed and updated as necessary and no less than every two years.

**Monitoring and Auditing:** The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.

**Documentation:** Documentation related to this policy must be maintained for a minimum of 10 years.

### **Applies to:**

|                                                                                    |                                                             |
|------------------------------------------------------------------------------------|-------------------------------------------------------------|
| <input checked="" type="checkbox"/> SummaCare APEX                                 | <input checked="" type="checkbox"/> Summa Insurance Company |
| <input checked="" type="checkbox"/> Service Management Service Organization (SMSO) |                                                             |

### **Line of Business (check all that apply):**

|                                                           |                                                 |
|-----------------------------------------------------------|-------------------------------------------------|
| <input checked="" type="checkbox"/> Commercial Groups     | <input checked="" type="checkbox"/> Medicare    |
| <input checked="" type="checkbox"/> Medicare Supplemental | <input checked="" type="checkbox"/> On Exchange |
| <input checked="" type="checkbox"/> Off Exchange          | <input checked="" type="checkbox"/> Self-Funded |

## **1.0 Purpose:**

Identify requirements for determining a covered acute hospital inpatient stay.

1.1: For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

1.2: For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate.

## **3.0 Review Process and Authorization**

### **3.1 Observation vs. Inpatient:**

3.1.1: Outpatient with Observation Services is used for short-term monitoring and treatment) and does not require prior authorization.

3.1.2: Inpatient stay always requires prior authorization and is appropriate when the patient's clinical condition, risk, or intensity of required services cannot be safely managed at an observation or outpatient level of care.

3.2: Preauthorization: Required for all elective/planned inpatient stays. Requests must include the admitting diagnosis, estimate length of stay, and supporting clinical data (vitals, labs, imaging, and physician notes).

3.3: Concurrent Review: Performed daily for ongoing medical necessity. Reviewers apply InterQual® guidelines, or equivalent SummaCare Medical Policies with approved criteria. InterQual® guidelines is available at SummaCare.Com.

3.4: Post-Discharge Review: Conducted to confirm documentation supports inpatient level of care and appropriate discharge timing.

3.5: The use of National Coverage Determinations, Local Coverage Determinations, CMS Inpatient Only List, InterQual criteria, SummaCare Medical Policies, etc. are identified in the annual UM Policy and on our SummaCare.com webpage

**4.0 Prior Authorizations:** All planned inpatient stays require prior authorization from the insurer. Emergency admissions must be reported to the insurer within 24 hours of admission to qualify for coverage. An inpatient stay, regardless of LOS, is medically necessary when all of the following are met:

4.1: Clinical Severity: The member presents with an acute condition that requires hospital-level care (e.g., unstable vital signs, severe pain, risk of deterioration, or need for close monitoring).

4.2: Intensity of Services: The care requires continuous nursing assessment, frequent physician evaluation, or diagnostic and therapeutic interventions that cannot safely be provided at an outpatient or observation level.

4.3: Expected Length of Stay: Based on clinical judgment and established guidelines, the patient is expected to require hospital-level care

4.4: Treatment Plan: The admitting provider documents a plan of care that includes specific discharge goals and identified anticipated LOS,

4.5 Documentation: The medical record includes:

- 4.5.1 Admission notes describing severity, interventions, and rationale for inpatient status.
- 4.5.2 Daily progress notes confirming improvement or ongoing need for inpatient care.
- 4.5.3 Discharge summary documenting condition at discharge and follow-up plan.

4.6: Two-Midnight Rule (applies to Medicare only): CMS presumes inpatient admission is appropriate when the physician expects the patient to require a hospital level of care that crosses two midnights.

4.7 Inpatient-Only (IPO) Procedures (applies to Medicare only):

Specific surgical or interventional procedures designated by CMS as inpatient-only, reimbursable only when performed under inpatient status, regardless of expected length of stay.

## 5.0 Exclusion Criteria

5.1: A short inpatient stay is not medically necessary when:

- 5.1.2: The condition can be safely managed in observation or outpatient status.
- 5.1.3: The patient is admitted primarily for convenience, social reasons, or non-medical needs (e.g., waiting for placement).
- 5.1.4: The admission is for diagnostic testing only without acute instability.

## 6.0 Definitions

- **Medically Necessary**: Services or care provided by a licensed medical professional that are consistent with accepted medical standards and not for the convenience of the patient or provider.
- **Covered Facility**: Any network hospital or inpatient healthcare facility licensed and accredited by the relevant governing authority.

## 7.0 References

- UM Plan
- Medicare Benefit Policy Manual Chapter 1: Inpatient Services
- Medicare Benefit Policy Manual Chapter 2: Inpatient Psychiatric Services