



Coverage Criteria for Inpatient Hospital Services and Outpatient Observation

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[MCG Care Guidelines](#)

Coverage Rationale

Inpatient Hospital Services and Outpatient Observation

All hospital services must be reasonable and necessary to be covered. The appropriate setting for hospital care must be determined based on the member's clinical condition, documented medical needs, applicable Medicare requirements, and the independent professional medical judgment of the physician or other qualified health care professional responsible for the member's care.

Inpatient admission is medically necessary when the medical record supports that the member requires hospital care at an inpatient level of care. This determination is based on the physician's expectation, at the time of the admission order, that the member will require medically necessary hospital services spanning at least two midnights, or that the member otherwise meets a recognized exception to the two-midnight benchmark. The admitting practitioner's judgment must be supported by the medical record and must reflect the member's condition, anticipated course of treatment, and the clinical factors that make inpatient care reasonable and necessary. [42 CFR § 412.3(d)(1) and (d)(3); Medicare Benefit Policy Manual, Chapter 1, §10; Medicare Program Integrity Manual, Chapter 6, §6.5]

Medical necessity for inpatient admission is met when the documentation demonstrates that the member's severity of illness, intensity of required services, risk of clinical deterioration, and anticipated need for hospital-based care cannot be safely, effectively, or reasonably provided in a lower level of care, including outpatient observation. The determination should consider the totality of the clinical circumstances rather than any single factor in isolation.

- The members' presenting signs, symptoms, diagnosis, comorbidities, functional status, and overall clinical stability;
- The likelihood and potential severity of an adverse event or clinical deterioration without inpatient-level monitoring, treatment, or intervention;
- The type, frequency, duration, and complexity of services required, including whether the services require hospital resources available only or most appropriately in the inpatient setting;
- The anticipated duration of medically necessary hospital care, including whether the physician reasonably expects the member to require care spanning at least two midnights;
- Whether diagnostic testing, therapeutic services, monitoring, or reassessment can reasonably be completed in an outpatient or observation setting;
- The availability and appropriateness of outpatient, observation, inpatient, or other care settings based on the member's clinical needs and the capabilities of the facility at the time and location of presentation; and
- Applicable Medicare coverage requirements, local coverage policies, health plan medical policies and WellMed medical policies.

For Medicare coverage of an inpatient admission to be appropriate, the documentation must clearly support the medical necessity of the inpatient level of care, including the clinical rationale for why outpatient observation or another lower level of care would not meet the member's needs. Hospital care that is custodial, provided primarily for convenience, or not required for the diagnosis or treatment of illness or injury is not medically necessary for inpatient coverage or payment. Extensive delays in providing medically necessary services are excluded from time counted toward the two-midnight benchmark. [Medicare Program Integrity Manual, Chapter 6, §6.5.2(A)(1)(B)]

Concurrent and retrospective review of inpatient admissions is based on whether the complex medical factors documented in the medical record support the medical necessity of the inpatient admission. The physician's order and expectation are important, but they must be supported by objective clinical documentation, the member's condition at the time of admission, the treatment plan, and the anticipated need for inpatient hospital services. [42 CFR § 412.3(d)(1) and (d)(3)]

An inpatient admission may also be appropriate when a medically necessary procedure is designated by Medicare as inpatient-only, regardless of the expected or actual length of stay. In addition, for hospital stays expected to span less than two midnights, an inpatient admission may be appropriate on a case-by-case basis when the medical record demonstrates that the severity of illness and intensity of service support inpatient care. [42 CFR § 412.3(d)(3)]

Observation may be more appropriate when the member requires hospital-based short-term treatment, monitoring, diagnostic evaluation, assessment, or reassessment, but the documentation does not support a reasonable expectation of medically necessary inpatient hospital care spanning at least two midnights and does not support an applicable inpatient exception. Observation is intended to allow the physician or



authorized practitioner to determine whether the member can be safely discharged or requires inpatient admission. When the physician or health care professional is uncertain whether inpatient admission is appropriate, outpatient observation should be considered.

Observation services are outpatient services and are covered when ordered by a physician or other individual authorized by state law and hospital bylaws to admit patients or order outpatient services. Observation services are medically reasonable and necessary when they provide a defined period of short-term treatment, monitoring, assessment, or reassessment before a decision is made to discharge the member or admit the member as an inpatient. In most cases, this decision can be made in less than 48 hours, and usually in less than 24 hours. Observation services extending beyond 48 hours should occur only in rare and exceptional circumstances when supported as medically reasonable and necessary. [Medicare Benefit Policy Manual, Chapter 6, §20.6; Medicare Claims Processing Manual, Chapter 4, §290 and §290.2.2]

- Observation may be appropriate when the member's condition requires continued monitoring or treatment to clarify diagnosis, response to therapy, clinical trajectory, or disposition, but the documented severity and intensity do not support inpatient admission.
- Observation should not be used when the services are not reasonable and necessary, are provided for convenience, are part of routine recovery from another service, are custodial in nature, or are otherwise not separately billable as observation under applicable Medicare billing guidance.
- Local Coverage Determinations and Local Coverage Articles apply when available and must be followed where applicable.

Use of Supplemental Criteria

- WellMed may use health plan medical policies and evidence-based medical literature to support consistent review of inpatient and observation level-of-care determinations. These criteria supplement, but do not replace, applicable Medicare requirements or the independent professional medical judgment of the treating physician or qualified health care professional.
- WellMed uses MCG Care Guidelines® as a source of medical evidence to support medical necessity and level-of-care decisions. MCG Care Guidelines® criteria are intended to be applied with clinical judgment and consideration of the member-specific facts documented in the medical record.
- Use of supplemental criteria promotes consistent consideration of clinical factors such as patient history, comorbidities, severity of illness, current medical needs, intensity of service, risk of adverse events, and appropriateness of the care setting. These criteria should support appropriate approval of inpatient admissions when medically necessary and appropriate use of observation when inpatient-level care is not supported.

Refer to the following sources, as applicable:

42 CFR § 412.3(d)(1) and (d)(3);

Medicare Benefit Policy Manual, Chapter 1, §10, Inpatient Hospital Services Covered Under Part A;

Medicare Benefit Policy Manual, Chapter 6, §20, Outpatient Hospital Services;

Medicare Benefit Policy Manual, Chapter 6, §20.6, Outpatient Observation Services;

Medicare Program Integrity Manual, Chapter 6, §6.5 and §6.5.2(A)(I)(B);

Medicare Claims Processing Manual, Chapter 4, §290 and §290.2.2;

National Coverage Determination 70.5;

CMS Reviewing Hospital Claims for Admission Memo;

CMS FAQs Two-Midnight Inpatient Admission Guidance and Patient Status Reviews;

applicable LCDs and LCAs; and applicable health plan medical policies

- As described in the commercial policies referenced above, MCG® may be used as a source of medical evidence to support medical necessity and level of care decisions. MCG® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider.

Outpatient Observation Services

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to plan, concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Hospitals may bill for patients who are "direct referrals" to observation. A "direct referral" occurs when a physician in the community refers a patient to the hospital for observation, bypassing the clinic or emergency department (ED). Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.



When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.

All hospital observation services, regardless of the duration of the observation care, that are medically reasonable and necessary are covered

Coverage Summary

Criteria Utilized

WellMed uses MCG Care Guidelines® as supplemental resources when reviewing the medical necessity of inpatient hospital admissions and outpatient observation services. These criteria are used alongside applicable Medicare statutes, regulations, CMS guidance, and the clinical judgment of the reviewing clinician.

MCG is intended to support consistent application of Medicare requirements across a wide range of clinical scenarios. They do not replace Medicare coverage rules and are not used in a manner that is more restrictive than Medicare requirements.

Clinical Rationale

Determining whether a member requires inpatient admission or can be safely managed in observation status often involves complex clinical decision-making. Reviewers must consider the severity of the presenting condition, underlying comorbidities, response to treatment, risk of deterioration, anticipated resource needs, and the expected course of care.

While Medicare establishes the framework for inpatient and observation coverage, including the Two-Midnight Rule and inpatient-only procedures, it generally does not provide detailed clinical parameters for every presentation encountered in utilization review. MCG helps fill that gap by offering nationally recognized clinical criteria that can be applied consistently while still allowing for case-by-case clinical judgment.

The use of MCG supports a thorough review of the member's individual clinical circumstances and assists in determining whether the requested level of care is appropriate. Final determinations are based on the complete clinical record and not on criteria alone

Medicare Alignment / Supplementation Analysis

Medicare Criteria Being Supplemented

This coverage policy supplements, but does not replace, existing Medicare requirements including:

42 CFR §412.3(d)(1) and §412.3(d)(3)

Medicare Benefit Policy Manual, Chapter 1, Section 10

Medicare Benefit Policy Manual, Chapter 6, Section 20.6

Medicare Program Integrity Manual, Chapter 6, Section 6.5

Medicare Claims Processing Manual, Chapter 4, Sections 290 and 290.2.2

Why Supplementation Is Necessary

Medicare provides the governing standards for inpatient admission and observation services; however, those standards do not always contain detailed clinical criteria that can be applied uniformly across the wide variety of conditions and presentations seen in hospital settings.

MCG are used to supplement Medicare requirements by providing additional clinical guidance for evaluating factors such as severity of illness, intensity of services, clinical stability, risk of adverse outcomes, and the most appropriate level of care. Their use promotes consistency in review decisions while maintaining alignment with Medicare requirements and preserving clinician judgment.

MCG serve as decision-support tools only. Coverage determinations remain rooted in Medicare requirements and the specific clinical circumstances of each member.

Benefits Versus Harms Analysis

The use of MCG criteria provides clinical value by supporting consistent, objective review of inpatient and observation requests. These criteria help reviewers evaluate whether the member's condition warrants inpatient hospitalization or whether care can be safely provided in a lower level of care.

Potential benefits include:

More consistent application of Medicare coverage requirements.

Improved identification of members who require inpatient-level services.

Reduction in unnecessary variation in utilization review decisions.

Appropriate use of observation services when inpatient admission is not supported.

Support for evidence-based and clinically appropriate level-of-care determinations.

Potential risks include the possibility that criteria could be applied too rigidly and contribute to delayed or denied access to medically necessary services.

Those risks are mitigated by requiring reviewer consideration of the complete medical record, provider documentation, member-specific circumstances, and independent clinical judgment. MCG is not used as stand-alone decision-making tools and do not replace individualized clinical review.



For these reasons, the clinical benefits of using MCG are expected to outweigh potential harms, particularly because their use promotes more consistent and clinically appropriate level-of-care determinations while remaining aligned with Medicare coverage requirements.

Clinical Evidence Summary

MCG are nationally recognized utilization management resources developed using published clinical literature, evidence-based practice recommendations and expert clinical review.

These criteria are designed to assist in evaluating the appropriateness of inpatient and observation services by incorporating clinical indicators associated with severity of illness, intensity of service, risk of deterioration, and expected resource utilization. The criteria are regularly updated to reflect current evidence and evolving standards of care.

The use of structured clinical criteria in conjunction with Medicare requirements supports consistent, clinically grounded review of hospital level-of-care requests while preserving individualized assessment of each member's condition and treatment needs

Evidence Sources / References

42 CFR §412.3(d)(1) and §412.3(d)(3)

Medicare Benefit Policy Manual, Chapter 1, Section 10

Medicare Benefit Policy Manual, Chapter 6, Section 20

Medicare Benefit Policy Manual, Chapter 6, Section 20.6

Medicare Program Integrity Manual, Chapter 6, Sections 6.5 and 6.5.2(A)(I)(B)

Medicare Claims Processing Manual, Chapter 4, Sections 290 and 290.2.2

National Coverage Determination (NCD) 70.5

CMS Reviewing Hospital Claims for Admission Guidance

CMS Two-Midnight Rule Guidance and Frequently Asked Questions

MCG Care Guidelines® Inpatient & Observation Level of Care Criteria