UnitedHealthcare Medicare Advantage hospital services review process

Effective Jan. 1, 2024

Does UnitedHealthcare follow the two-midnight benchmark?

Yes. UnitedHealthcare complies with general coverage and benefit conditions included in Original Medicare laws, unless superseded by laws applicable to Medicare Advantage plans. This includes payment criteria for inpatient admissions at 42 CFR 412.3, such as the "two-midnight benchmark" (§ 412.3(d)(1)).

Does UnitedHealthcare follow the two-midnight presumption?

No. The "two-midnight presumption" is a medical review instruction given to Medicare fee-for-service contractors to guide selection of claims for medical necessity review. Under this presumption, inpatient stays that cross 2 midnights after formal admissions are "presumed" appropriate for payment and are generally not the focus of medical review. CMS has confirmed the two-midnight presumption does not apply to Medicare Advantage plans.[1]

Does UnitedHealthcare use medical necessity criteria?

Yes. The CMS Final Rule expressly allows Medicare Advantage plans to adopt internal coverage criteria when the applicable coverage criteria in Original Medicare laws, national coverage determinations (NCDs) and local coverage determinations (LCDs) are not fully established. Coverage criteria are not fully established when, for example, "additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently."[2]

CMS acknowledged that Original Medicare statutes, regulations, NCDs and LCDs do not always contain specific criteria for making medical necessity determinations in every situation for every applicable Part A or B service. When that occurs, CMS has specifically noted that plans may create internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature.[3] CMS expressly allows for Interqual criteria to be used to assist in creating internal coverage criteria.[4]

UnitedHealthcare develops and maintains Medicare Advantage coverage summaries, which set forth the coverage information and guidelines specific to UnitedHealthcare Medicare Advantage plans for particular types of services. The Hospital, Emergency and Ambulance Services Medicare Advantage Coverage Summary explains the general Medicare coverage requirements and the more detailed UnitedHealthcare Commercial Hospital Services: Observation and Inpatient **medical policy** criteria, including Interqual criteria for inpatient hospital services as a source of medical evidence.

[1] CMS Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, 88 Fed. Reg. 22120, 22191-22192 (Apr. 12, 2023).
[2] See 88 F.R. 22192 and 42 C.F.R. 422.101(b)(6)(i)(A)-(C).
[3] Id.
[4] See 88 F.R. 22195.

Does time alone (2 midnights) suffice for an inpatient admission to be covered?

No. All hospital services must be reasonable and necessary to be covered at the inpatient level. We will review inpatient admissions to determine whether the complex medical factors documented in the patient's medical record support the admitting physician's reasonable expectation that the patient requires hospital care that crosses 2 midnights. Reviewers will apply this and other criteria in the Hospital, Emergency and Ambulance Services Medicare Advantage Coverage Summary, the UnitedHealthcare Commercial Hospital Services: Observation and Inpatient medical policy and Interqual criteria as a source of medical evidence to conduct these medical necessity reviews.

Hospital care that is custodial, rendered for reasons of convenience or not required for the diagnosis or treatment of illness or injury is not appropriate for coverage or payment. Any extensive delays in the provision of medically necessary services are excluded from time counted towards the two-midnight benchmark.

Do stays of less than 24 hours generally meet payment criteria for inpatient admission?

No. CMS has explained that hospital stays under 24 hours rarely qualify for payment as an inpatient stay.[5] All hospital services must be reasonable and necessary to be covered at the inpatient level. We will review based on whether the complex medical factors documented in the medical record support the medical necessity of inpatient admission. Reviewers will apply the criteria in the Hospital, Emergency and Ambulance Services Medicare Advantage Coverage Summary, the UnitedHealthcare Commercial Hospital Services: Observation and Inpatient medical policy and Interqual criteria as a source of medical evidence.

However, if a member was admitted but received hospital services that do not cross 2 midnights (including observation/outpatient time), the inpatient admission may be appropriate for payment in cases of unexpected death, unexpected discharge against medical advice, unexpected transfer, unexpected hospice or unexpected rapid improvement.[6] Documentation of the physician's reasonable expectation that the stay would cross 2 midnights, and the reason why it did not, must be included in the medical record.[7]

What is the case-by-case exception?

The "case-by-case exception" refers to criteria for payment of an inpatient admission for a member not expected to require hospital care crossing 2 midnights (including any observation stay (OBS)/outpatient time). Review under the case-by-case exception typically requires the clinical judgment of a UnitedHealthcare medical director evaluating the physician's decision based on the documented complex medical factors including, but not limited to: the member's history and comorbidities, severity of signs and symptoms, current medical needs and risk of an adverse event.

Does UnitedHealthcare follow CMS's Inpatient Only (IPO) list?

Yes. Inpatient admissions where a medically necessary inpatient-only procedure is performed meet criteria for inpatient admission regardless of expected or actual length of stay.

[5] **CMS Reviewing Hospital Claims for Admission Memo**
[6] Id.
[7] Id.

Resources:

- **Medicare Benefit Policy Manual, Chapter 1, §10 – Inpatient Hospital Services Covered Under Part A**
- **National Coverage Determination (NCD) for Hospital and Skilled Nursing Facility Admission Diagnostic Procedures (70.5)**
- **Medicare Program Integrity Manual, Chapter 6, § 6.5**
- **CMS Reviewing Hospital Claims for Admission Memo**
- **CMS FAQs 2 Midnight Inpatient Admission Guidance & Patient Status Reviews for Admissions on or after October 1, 2013**
- 42 CFR § 412.3(d)(1) and (d)(3); 88 Fed. Reg. 22191 (Apr. 12, 2023)
- Medicare Program Integrity Manual, Ch. 6, § 6.5.2(A)(I)(B)

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