Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Inpatient Acute and Post-Acute Levels of Care (Medical/Surgical)

Effective: July 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	Yes ☒ No ☐
Notification Required (Concurrent review may be required)	Yes ☒ No☐

Applies to:

- Harvard Pilgrim Health Care Commercial products
- Tufts Health Plan Commercial products
- Tufts Health Direct
- Tufts Health Together
- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product). For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™

- **Tufts Health Plan Commercial Plan products**: If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404.
- **Tufts Health Public Plans products**: InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Subsets or Smartsheet(s) to obtain prior authorization. In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s). The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan.

Overview

Point32 Health uses InterQual as a source of medical evidence to support medical necessity for procedures, durable medical equipment, and level of care decisions, when indicated. InterQual criteria are intended for use in conjunction with the independent medical review of a qualified health care provider and do not constitute the practice of medicine or medical advice. In addition, InterQual Clinical Content reflects clinical interpretations and analyses and cannot alone resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Clinical Content is intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

Observation services are an alternative level of care appropriate for some shorter hospital admissions.
Because the most appropriate level of care may not be evident until an observation period has been completed, Point32Health has developed a payment policy to assist with the determination of observation versus acute inpatient level of care for hospital stays 48 hours or less. This payment policy will apply to Harvard Pilgrim Health Care and Tufts Health Plan Commercial products and Tufts Health Direct as noted below.

Clinical Guideline Coverage Criteria

The Plan requires notification following an acute inpatient admission. Concurrent review may also apply depending on the length of admission.

Prior authorization is required for elective surgical inpatient admissions. Please note that a separate prior authorization may be required for the planned surgical procedure. Refer to the specific prior authorization resources for additional information: https://www.point32health.org/provider/policies/prior-authorization/resources.

Prior authorization is required for the following post-acute levels of care: Long Term Acute Care, Inpatient Acute Rehabilitation, and Subacute/Skilled Nursing Facility.

Inpatient admissions will be subject to review using InterQual criteria to determine appropriateness of inpatient level of care.

	Prior Authorization	Notification
Inpatient hospital admission following emergency treatment		X
Observation status change to inpatient admission		X
Surgical day care resulting in inpatient admission		X
Elective inpatient admission for surgeries or procedures	X	
Inpatient Acute Rehabilitation	X	
Long Term Acute Care	X	
Subacute/Skilled Nursing Facility (SNF)	X	

Harvard Pilgrim Health Care and Tufts Health Plan Commercial Products and Tufts Health Direct

The Plan will review requests for a short inpatient stay of 48 hours or less to determine if it is more appropriate to categorize the encounter as an observation stay rather than at an inpatient level of care in accordance with the Observation Stay Payment Policy

- Admissions where the duration of inpatient level care is 48 hours or less will be administratively classified as observation level of care, unless certain exceptions are present as defined in the above cited payment policy, without additional review for inpatient level of care

- In instances where the admission extends beyond the observation time frame, or an exception is established as noted in the above payment policy, a medical necessity review using InterQual® * will be conducted to determine the appropriateness of acute inpatient level of care.

References:

1. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B Medicare Benefit Policy Manual (cms.gov). 100-02 | CMS. Accessed April 27, 2026.
2. Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A Medicare Benefit Policy Manual (cms.gov). 100-02 | CMS. Accessed April 27, 2026.
3. Centers for Medicare & Medicaid Services (CMS). (CY) 2025 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Final Rule [CMS-1809-F] Published November 1, 2024. Accessed February 24, 2025.
4. Centers for Medicare & Medicaid Services (CMS). Acute Inpatient PPS. Three Day Payment Window. Implementation of New Statutory Provision Pertaining to Medicare 3-Day (1-Day) Payment Window Policy - Outpatient Services Treated As Inpatient. Three Day Payment Window | CMS. Accessed April 27, 2026.
5. Centers for Medicare & Medicaid Services (CMS). Fact Sheet: Two-Midnight Rule, March 12, 2026. Two Midnight Rule Fact Sheet. Accessed April 27, 2026.
6. U.S. Department of Health and Human Services, Office of Inspector General, CMS Oversight of the Two-Midnight Rule for Inpatient Admissions (hhs.gov); CMS Oversight of the Two-Midnight Rule for Inpatient Admissions (hhs.gov). Accessed April 27, 2026.

Approval And Revision History

November 16, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration purposes between Harvard Pilgrim Health Care and Tufts Health Plan, effective January 1, 2023.

Subsequent Endorsement Dates and Changes Made:

- December 1, 2022: Reviewed by MPAC, renewed without changes
- June 21, 2023: Reviewed by MPAC for 2023 InterQual Upgrade, effective August 1, 2023
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care effective January 1, 2024
- December 1, 2023: Reviewed and approved by the UM Committee effective January 1, 2024
- June 13, 2024: Reviewed and approved by the UM Committee, effective July 1, 2024
- June 20: 2024: Reviewed by MPAC for the 2024 InterQual Upgrade effective July 1, 2024
- October 17, 2024: Reviewed by MPAC; updated MNG in light of new Observation Stay Payment Policy that will address short inpatient stays of less than 48 hours for Commercial products and Tufts Health Direct, MNG renamed “Inpatient Acute and Post-Acute Levels of Care (Medical/Surgical) effective January 1, 2025
- April 16, 2025: Reviewed by MPAC for annual review and removed the following statement “For Tufts Health Together, RI Together and One Care plan medically necessary observation stays may be authorized for greater than 48 hours. Notification is required within one business day from the beginning of the observation stay using the Inpatient Notification Form” effective August 1, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual Update effective July 1, 2025.
- June 17, 2025: Harvard Pilgrim Health Care Stride Medicare Advantage removed as an applicable product from the template
- August 20, 2025: Reviewed by MPAC for annual review, renewed without changes effective October 1, 2025
- September 17, 2025: Reviewed by the UM Committee, renewed without changes effective October 1, 2025
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update and Annual Review; administrative update to guideline template and clarified acute inpatient admission requires notification and post acute levels of care require prior authorization; effective July 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.