CLINICAL MEDICAL POLICY	
Policy Name:	Observation and Inpatient Admissions
Policy Number:	MP-144-MD-PA
Responsible Department(s):	Medical Management
Provider Notice/Issue Date:	01/01/2026
Effective Date:	03/01/2026
Next Annual Review:	11/2026
Revision Date:	11/19/2025
Products:	Highmark Wholecare℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 3

Policy History

Date	Action
03/01/2026	Provider Effective date
11/18/2025	PARP Approval
10/29/2025	QI/UM Committee review
10/29/2025	Policy initially developed

Disclaimer

Highmark Wholecare℠ medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark WholecareSM may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary observation and/or inpatient admissions.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

(Current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirements)

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This policy will be applied consistent with current applicable Pennsylvania HealthChoices Agreement Section V. Program Requirements, B. Prior Authorization of Services, 1. General Prior Authorization Requirement and governing law.

Definitions

Prior Authorization Review Panel (PARP) – A panel of representatives from within the PA Department of Human Services who have been assigned organizational responsibility for the review, approval and denial of all PH-MCO Prior Authorization policies and procedures.

Procedures

Note: Prior authorization is not required for an Observation stay.

1. An observation hospital stay can be managed for ANY of the following conditions/symptoms (this is not an all-inclusive list):
    - Abdominal pain
    - Allergic reaction (generalized)
    - Altered mental status (confusion)
    - Anemia
    - Asthma
    - Atrial fibrillation
    - Back pain
    - Bronchiolitis
    - Bronchitis
    - Cellulitis
    - Chest pain
    - Chronic obstructive pulmonary disease (COPD)
    - Croup
    - Dehydration
    - Diabetes mellitus
    - Epistaxis
    - Febrile illness
    - Gastroenteritis
    - Heart failure
    - Hemoptysis
    - Migraine
    - Pneumonia
    - Poisoning/Toxic ingestions
    - Renal colic, kidney stone
    - Seizures
    - Syncope and collapse
    - Transient ischemic attack (TIA)
    - Urinary tract infection (UTI)
    - Vaginal bleeding (non-obstetrical)
    - Weakness

2. Observation services are considered medically necessary when an individual requires the following services in any location within a hospital:

A. A condition that requires short-term monitoring for at least eight (8) hours of assessment or treatment and improve significantly within 24-48 hours; AND

B. ANY ONE of the following:

1) Diagnostic evaluation to establish a treatment plan; OR

2) Event monitoring (e.g., cardiac dysrhythmia) or response to therapy (e.g., from drug ingestion) that may require immediate intervention; OR

3) Acute treatment and reassessment.

Note: Observation services for the convenience of the hospital, physicians, patients, patient's families, or while awaiting transfer to another medical facility will be considered not medically necessary.

3. For stays less than two midnights, there is generally no review for medical necessity because the stay will typically be managed as observation level of care unless one of the following exceptions is met (These exceptions presume an inpatient admission)

A. Emergent mechanical ventilation has been initiated current present visit; OR

B. Individual was transferred to/from another hospital; OR

C. Individual was transferred to inpatient hospice or comfort measures put in place; OR

D. Delivery (maternal or newborn); OR

E. Individual has left against medical advice; OR

F. Individual has died.

4. A medical necessity review for inpatient admission is required

- A minimum of two (2) days of clinical documentation (including, if applicable, documentation from an individual's observation period) must generally be submitted with the medical necessity review. An inpatient medical necessity review request submitted without a minimum of two (2) days of clinical documentation may be administratively denied.
- A two (2) midnight or beyond hospital admission will be considered outpatient (ambulatory or Observation) if inpatient medical necessity criteria are not met.

5. Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark WholecareSM at any time pursuant to the terms of your provider agreement.

Reimbursement

Participating facilities will be reimbursed per their Highmark WholecareSM contract.

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