

Provider FAQ:

Medicare inpatient acute admissions

Effective Sept. 1, 2026, the health plan will no longer require prior authorization for **Medicare inpatient acute admissions, for medical admissions only**.^{*} Instead, claims will be reviewed after submission to ensure coverage and level of care requirements are met. We may request medical records to support our review. This change will impact our Medicare plans only (including Medicare Advantage, D-SNP and HIDE-SNP).

^{*}Note: authorization will still be required for behavioral health cases.

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General

Why is Priority Health making this change?

This change is designed to:

- Eliminate authorization requirements at the point of admission, for Medicare inpatient acute cases (medical only)
- Reduce barriers to care
- Align with industry movement toward post service review for acute care

Level of care and benefit coverage requirements have not changed.

Does this mean all inpatient stays will be approved or paid automatically?

No. While prior authorization is no longer required for Medicare inpatient acute medical cases, all inpatient admissions are still subject to coverage, benefit and level of care review. Claims may be denied if criteria are not met.

Level of care & admission criteria

How will inpatient level of care be evaluated?

Focusing on shorter lengths of stay, Medicare inpatient level of care (medical only) will be evaluated after claim submission using:

- InterQual guidelines, CMS criteria, plan medical policies
- Clinical documentation, if requested after claim submission
- Medical records accessed through direct EMR sharing

Excluded from claim review:

- Member deaths
- ICU admissions

Are clinical criteria changing?

No. The criteria used to evaluate inpatient admissions remain unchanged.

How are short stays reviewed?

Short stays will be reviewed to confirm:

- Severity of illness
- Intensity of services
- Appropriateness of inpatient level of care versus observation

Clear physician documentation is critical.

Are observation services impacted by this change?

No. Observation services continue to follow existing billing and coverage guidelines and are evaluated separately from inpatient admissions.

Claims review & payment

When will the health plan review inpatient admissions?

Review occurs after the Medicare inpatient acute claim is submitted and based on:

- Claim data
- Supporting clinical documentation, if requested or accessed via EMR sharing
- Applicable coverage and medical necessity criteria

How long does the post-claim review process take?

Claims are reviewed according to standard claim processing timelines outlined in your provider agreement and state and federal regulations.

Will providers receive notification if a claim does not meet criteria?

Yes. If a claim is denied, a denial explanation will be provided in the remittance advice (RA).

How will providers be notified if medical records are necessary for claim review?

We'll notify providers through the following methods:

- Provider portal message (for in-network providers)
- Letter (for both in- and out-of-network providers)

What's the turnaround time for submission of requested medical records?

Medical records should be submitted within 30 days of the request. See billing policy [182 – Technical Denials](#) for more information.

How can providers submit requested medical records?

Providers can submit requested medical records through our provider portal or fax.

To reduce administrative burden, consider allowing Priority Health read-only access to your EMR. Reach out to your Provider Network Management Consultant (for ACNs) or our Provider Helpline at 800.942.4765 for details.

What happens if a provider doesn't submit the requested medical records?

If requested information has not been received within 30 calendar days unless otherwise specified, the claim will be denied for insufficient documentation. See billing policy [182 – Technical Denials](#) for more information. See Denials & Appeals below.

Documentation expectations

What documentation is required to support inpatient medical necessity?

If requested via the portal or letter during claim review, your documentation should clearly support:

- Reason for inpatient admission (inpatient order, including time / date stamp)
- Clinical severity and/or risk
- Intensity of services provided
- Ongoing need for inpatient level of care
- Commonly reviewed documents include:
 - History & physical
 - Progress notes
 - Consult notes
 - MAR
 - Imaging studies
 - Pertinent labs
 - Discharge summary

Denials & disputes

Can inpatient claims be denied for inpatient level of care after discharge?

Yes. Claims selected for review may be denied for inpatient level of care if documentation does not demonstrate medical necessity or benefit coverage. This is consistent with post-claim review processes.

What is the appeal process?

Providers may dispute denied claims by submitting:

- Additional clinical documentation
- Physician statements, if applicable
- Disputes within the timeframes specified in the Provider Manual

All claim disputes are reviewed by qualified clinical professionals. [See our Provider Manual](#) for instructions.

Will payment be recouped after payment is issued?

If a post-payment review determines the admission does not meet criteria and payment was issued in error, recovery may occur.

What is not changing

What aspects of Medicare inpatient review are not changing?

- Definitions of medical necessity
- Coverage benefits
- Clinical review criteria
- Regulatory compliance requirements

The following won't be subject to post-claim review:

- ICU admissions
- Member deaths

Additionally, established authorization processes for the following won't change:

- Commercial plans
- Medicaid plans
- Scheduled Medicare inpatient cases

Support & resources

Where can providers get help or ask questions?

Providers may contact:

- **Provider Helpline:** 800.942.4765
- **Provider portal:** provider.priorityhealth.com (login required)
- **Provider Manual:** priorityhealth.com/provider/manual
- **ACNs** can contact their Provider Network Management Consultant