Medical necessity” is a vague standard, subject to broad interpretation based on clinical practice and judgment. Yet it’s a crucial one to try to understand, as it determines whether Medicare, Medicaid and other health care payers will reimburse your hospital. Lack of medical necessity may also result in non-payment to physicians. Essentially, medical necessity means an illness must be severe enough, and the required services intense enough, that care can only be given safely and effectively in the hospital.

To provide some objective guidance, industry-standard guidelines have been developed over the past 30 years based on medical literature and professional practice guidelines. The most recognized and frequently used are the InterQual and Milliman criteria, which have been validated by research and decades of clinical use.

These guidelines are intended to be used as screening tools, so clinical judgment with supporting documentation of medical necessity should take precedence. Care provided to a patient must also be consistent with the need for inpatient admission. Governmental and commercial auditors are likely to challenge admissions when these inpatient criteria are not satisfied, and sometimes when they are. If a patient needs inpatient treatment that is not substantiated by these criteria, a physician needs to explain why clearly in the medical record.

Case managers can assist physicians with applying medical necessity criteria and documentation, but they are not always available for support. Fortunately, just a little knowledge of certain medical necessity expectations can guide physicians in marginal cases where the need for inpatient care is unclear.

Some clinical findings and expected management for inpatient medical necessity in the most common problematic conditions are discussed below. Keep in mind that these criteria are based on clinically appropriate professional recommendations but do not constitute clinical practice standards of care or replace physician judgment and expertise.

**Pneumonia**

Pneumonia is best confirmed by chest X-ray or chest computed tomography (CT). If not identified by imaging, pneumonia may still be diagnosed on clinical grounds as long as a specific reference is made to the clinical basis and the absence of radiographic findings is noted. If the patient does not receive a full course of antibiotics as indicated, the diagnosis of pneumonia will not be supported.

Deciding whether a patient with pneumonia needs to be admitted to the hospital, sent home for a trial of outpatient management, or observed for 24 hours may be challenging. The decision typically is based on many subjective and objective circumstances, such as age, functional status, social support, pre-existing conditions, vital signs, oxygenation and X-ray findings, among others.