

QUALCARE IPA

MCG Inpatient & Surgical Care (ISC)

2026 Medicare Advantage Coverage Summary / Third-Party Clinical Criteria

Delegate Organization	QualCare IPA
Third-Party Criteria	MCG Care Guidelines, 30th Edition
Criteria Set	MCG Inpatient & Surgical Care (ISC)
Population	UnitedHealthcare Medicare Advantage members for whom QualCare IPA performs delegated utilization management

1. Purpose and Scope

QualCare IPA uses MCG Inpatient & Surgical Care (ISC) criteria to support utilization-management determinations for acute inpatient admission, observation-versus-inpatient assessment, continued stay, surgical indications, procedural setting, and postoperative recovery. MCG is used as a supplemental clinical decision-support resource only after applicable Original Medicare coverage requirements have been identified. Medicare statutes, regulations, NCDs, LCDs, LCAs, and CMS manual provisions control whenever they establish the applicable coverage requirement.

MCG criteria do not replace physician judgment and are not applied as an automatic denial rule. Reviewers consider the member's complete clinical record, treating-practitioner documentation, comorbidities, functional status, prior treatment, response to treatment, contraindications, and the capabilities of alternative settings.

2. Medicare Criteria Being Supplemented

- Social Security Act §1862(a)(1)(A): services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- 42 CFR §422.101: Medicare Advantage organizations must provide coverage consistent with Original Medicare coverage requirements; when coverage criteria are not fully established, permissible supplemental criteria must be based on current evidence in widely used treatment guidelines or acceptable clinical literature.
- 42 CFR §422.137: utilization management policies and procedures are subject to annual review and approval by the Medicare Advantage Utilization Management Committee.
- Applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and CMS Internet-Only Manual provisions are reviewed first and control when they establish the applicable coverage rule.
- 42 CFR §412.3, including Medicare inpatient admission requirements and the two-midnight framework.
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 1 (Inpatient Hospital Services Covered Under Part A).
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6 (Hospital Services Covered Under Part B), including outpatient hospital/observation concepts where applicable.
- CMS Medicare Program Integrity Manual, Pub. 100-08, Chapter 6, medical review of inpatient hospital claims.
- CMS Inpatient Only List requirements and procedure-specific NCDs/LCDs/LCAs when applicable.

Medicare alignment rule: When Medicare has a fully established criterion for the requested item or service, QualCare applies that Medicare criterion. MCG is not used to create a more restrictive coverage rule. When Medicare criteria are absent or not fully established, MCG may be used to supply clinical specificity consistent with 42 CFR §422.101.

3. Explanation of the Need for Supplementation

Medicare determines whether inpatient hospital services are covered through statutes, regulations, manuals, the two-midnight policy, and other controlling rules. Those sources do not provide a complete diagnosis- and procedure-specific set of physiologic thresholds, treatment-intensity markers, operative indications, postoperative milestones, or expected recovery parameters for every condition. MCG ISC supplies that clinical specificity while Medicare rules remain controlling.

Supplementation is limited to clinical details necessary to interpret whether the requested service is reasonable and necessary for the individual member. Examples include severity, objective findings, prior treatment, treatment response, expected benefit, risk of delay, monitoring needs, site-of-service capability, and safe transition requirements.

4. Criterion-Specific Rationale Framework

QualCare does not rely on one generalized rationale for all determinations. The rationale is matched to the specific MCG guideline used. For each individual MCG guideline applied, the reviewer identifies the exact guideline title/number in the utilization-management record and applies the guideline-specific clinical indications, evidence summary, rationale, CMS coverage guidance, and references. The following table describes the distinct clinical questions within this criteria set that require criterion-specific analysis.

Clinical criterion/domain	Specific rationale question	Member-specific factors evaluated
Medical inpatient admission	Severity of illness, organ dysfunction, instability, failed lower-level treatment, required monitoring, and hospital-only therapies.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
Observation versus inpatient	Expected duration and intensity of medically necessary hospital care, response to initial treatment, unresolved risk, and Medicare's controlling inpatient-status rules.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
Surgical indication	Symptoms, objective disease, failed conservative treatment when appropriate, urgency, expected benefit, alternatives, and operative risk.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings; treating-practitioner documentation.
Postoperative recovery/continued stay	Hemodynamic stability, bleeding, pain control, oral intake, mobility, voiding, wound status, complications, and whether continued hospital-level care is required.	Diagnosis and symptoms; objective findings; severity/trajectory; comorbidities and contraindications; prior treatment/testing; expected benefit; risk of delay/non-treatment; alternative services/settings;

Clinical criterion/domain	Specific rationale question	Member-specific factors evaluated
		treating-practitioner documentation.

5. Detailed Statement of Rationale

Clinical benefits

ISC supports consistent identification of patients who require acute inpatient care or surgery and helps distinguish inpatient care from observation/outpatient management when the clinical course can safely be managed at lower intensity. Surgical criteria also help confirm that an intervention is supported by symptoms, objective findings, failed alternatives, urgency, and expected benefit.

Potential clinical harms

Inappropriate denial of inpatient or surgical care may delay definitive treatment, allow progression of infection or organ dysfunction, increase pain or disability, or increase emergency return and morbidity. Inappropriate admission or surgery can expose members to hospital-acquired complications, anesthesia and procedural risks, bleeding, infection, delirium, immobility, and unnecessary recovery burden.

Benefit-versus-harm analysis

The expected clinical benefits of using evidence-based, criterion-specific MCG guidance are likely to outweigh the potential harms when the criteria are applied as supplemental decision support rather than as a substitute for Medicare coverage rules or individualized clinical review. The principal benefit is a more consistent and reproducible assessment of medical necessity. The principal risk is inappropriate restriction if a criterion is applied without considering the full record, atypical presentation, comorbidity, or controlling Medicare requirements. QualCare mitigates that risk through individualized review, consideration of treating-practitioner information, application of Medicare criteria first, and physician/qualified health-professional review of adverse medical-necessity determinations as required.

Medicare Advantage population tailoring

Medicare Advantage members may have reduced physiologic reserve and higher perioperative risk because of age, frailty, cardiovascular disease, diabetes, renal disease, anticoagulation, and multimorbidity. ISC is applied to the complete clinical picture and does not rely on a single laboratory value or diagnosis label.

Comparative outcomes and access considerations

The comparison is not simply service versus no service. Reviewers consider the expected outcome with timely medically necessary care versus delayed or absent care, and the expected outcome of the requested setting or intervention versus a clinically appropriate alternative. Factors include likelihood of diagnostic or therapeutic benefit, morbidity and mortality associated with delay, risk of emergency escalation or readmission, adverse-event burden, functional consequences, and whether a less intensive alternative can safely achieve the same clinical objective.

6. Summary of Clinical Evidence

MCG ISC guidelines are supported by condition- and procedure-specific peer-reviewed literature and specialty guidance cited within each guideline. For every ISC guideline used, QualCare relies on the associated MCG Evidence Summary, Rationale, related CMS coverage guidance, and references. Evidence is considered in relation to severity, expected benefit of treatment, risk of delay, procedural risk, and the intensity and duration of hospital services required.

Consistent with the MAP-TAC submission instructions, QualCare relies on the supporting references and evidence summaries contained within the licensed MCG criteria and does not reproduce MCG's proprietary criterion text or full reference library in this public coverage summary. When QualCare relies on an external source beyond MCG and Medicare coverage authorities, the source should be added to the criterion-specific record with a full citation and a brief evidence summary.

7. Supporting References and Medicare Alignment

- Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual, Pub. 100-02, applicable chapters.
- CMS. Medicare Program Integrity Manual, Pub. 100-08, applicable medical-review provisions.
- CMS. Medicare Coverage Database: applicable NCDs, LCDs, and LCAs for the requested service.
- 42 CFR §§422.101 and 422.137; other service- and setting-specific Medicare regulations as applicable.
- Social Security Act §1862(a)(1)(A).
- MCG Health. MCG Care Guidelines, 30th Edition, MCG Inpatient & Surgical Care (ISC); individual guideline Evidence Summaries, Rationales, CMS Coverage Guidance, and References.
- 42 CFR §412.3, including Medicare inpatient admission requirements and the two-midnight framework.
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 1 (Inpatient Hospital Services Covered Under Part A).
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 6 (Hospital Services Covered Under Part B), including outpatient hospital/observation concepts where applicable.
- CMS Medicare Program Integrity Manual, Pub. 100-08, Chapter 6, medical review of inpatient hospital claims.
- CMS Inpatient Only List requirements and procedure-specific NCDs/LCDs/LCAs when applicable.

8. Transparency and Public Accessibility

Transparency Tool URL: <https://www.qualcareipa.com/MCG.aspx>

Coverage Summary URL: <https://www.qualcareipa.com/patientsmembers/>

Navigation Instructions: From the QualCare IPA public website, select <https://www.qualcareipa.com>, then Patients/Providers, select the applicable MCG criteria set, and follow the link to the MCG Transparency tool and this coverage summary.

Public-access statement: The public-facing materials identify the criteria used in utilization management and provide access to the applicable coverage summary. Proprietary MCG content is accessed through the authorized MCG transparency mechanism.

9. Operational Safeguards

- Apply applicable Medicare statutes, regulations, NCDs, LCDs, LCAs, and CMS manual provisions before supplemental MCG criteria.
- Document the exact MCG guideline title/number used for each medical-necessity determination.
- Do not deny solely because a member fails a single MCG element when Medicare coverage is otherwise established or when the total clinical record supports coverage.
- Consider treating-practitioner documentation and relevant member-specific circumstances, including comorbidities, functional status, contraindications, and atypical presentation.
- Route partially or fully adverse medical-necessity determinations for review by an appropriately licensed physician or other qualified health care professional with relevant experience and knowledge of Medicare criteria.
- Review and update this coverage summary at least annually and when there is a material change to the criteria set, Medicare requirements, or QualCare's utilization-management process.

10. Criterion-Level Submission Inventory

For MAP-TAC submission, QualCare should attach or maintain an inventory of every individual MCG guideline actually used within this criteria set. Each inventory entry should identify: MCG guideline title and number; applicable Medicare authority; whether Medicare criteria are absent or not fully established; the specific supplementation rationale; the criterion-specific benefit/harm rationale; the MCG evidence-summary/reference source; and the public transparency location. This inventory is the mechanism that converts the criteria-set summary into criterion-level documentation and avoids reliance on a single category-wide rationale.

MCG guideline title/ID	Medicare authority	Why supplementation is needed	Specific benefit/harm rationale	Evidence/reference source	Public access location
[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]	[Complete for each criterion used]

11. Approval and Review

Effective Date	[INSERT]
Annual Review Date	[INSERT]
Approved By	[INSERT UM Committee/MAP-TAC approval information]
Document Owner	QualCare IPA Utilization Management