Introduction

The Plan uses InterQual® to review certain services for medical necessity as listed in this guideline. InterQual is evidence-based criteria that offers guidance in covering medical and behavioral health for all levels of care in addition to care planning, complex care management, durable medical equipment, procedures, and specialty pharmacy.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
## Medical Necessity

The following services are considered medically necessary when criteria are met using InterQual® criteria:

<table>
<thead>
<tr>
<th>Module</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Adult</td>
<td>• Acute Kidney Injury</td>
</tr>
<tr>
<td></td>
<td>• Anemia/Bleeding</td>
</tr>
<tr>
<td></td>
<td>• Antepartum</td>
</tr>
<tr>
<td></td>
<td>• Asthma</td>
</tr>
<tr>
<td></td>
<td>• Carbon Monoxide Poisoning</td>
</tr>
<tr>
<td></td>
<td>• Cholecystitis</td>
</tr>
<tr>
<td></td>
<td>• Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td></td>
<td>• Cystic Fibrosis</td>
</tr>
<tr>
<td></td>
<td>• Deep Vein Thrombosis</td>
</tr>
<tr>
<td></td>
<td>• Diabetes Mellites (DM)</td>
</tr>
<tr>
<td></td>
<td>• Diabetic Ketoacidosis (DKA)</td>
</tr>
<tr>
<td></td>
<td>• Electrolyte/Mineral Imbalance</td>
</tr>
<tr>
<td></td>
<td>• Epilepsy</td>
</tr>
<tr>
<td></td>
<td>• Extended Stay</td>
</tr>
<tr>
<td></td>
<td>• General Medical</td>
</tr>
<tr>
<td></td>
<td>• General Trauma</td>
</tr>
<tr>
<td></td>
<td>• Heart Failure</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Acute Myeloid Leukemia</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Brain Malignancy/Metastasis</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Chemo</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Hemolytic Uremic Syndrome</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Malignant Disease</td>
</tr>
<tr>
<td></td>
<td>• Hematology/Oncology: Tumor Lysis Syndrome</td>
</tr>
<tr>
<td></td>
<td>• Hip arthrotyomy</td>
</tr>
<tr>
<td></td>
<td>• Hyperosmolar Hyperglycemic State</td>
</tr>
<tr>
<td></td>
<td>• Hypertension</td>
</tr>
<tr>
<td></td>
<td>• Hypertensive Disorder in Pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>• Infection: Central Nervous System (CNS)</td>
</tr>
<tr>
<td></td>
<td>• Infection: Endocarditis</td>
</tr>
<tr>
<td></td>
<td>• Infection: General</td>
</tr>
<tr>
<td></td>
<td>• Infection: Gastrointestinal/Genitourinary/Gynecology</td>
</tr>
<tr>
<td></td>
<td>• Infection: Musculoskeletal</td>
</tr>
</tbody>
</table>
### Medical Necessity

- Infection: Pneumonia
- Infection: Sepsis
- Infection: Skin
- Irritable Bowel Disease
- Labor & Delivery
- Pancreatitis
- Postpartum Complications After Discharge
- Pulmonary Embolism
- Quality Indicator Checklist
- Rhabdomyolysis or Crush Syndrome
- Sickle Cell Crisis
- Stroke
- Syncope
- Transient Ischemic Attack (TIA)
- Transition Plan (Continued Stay and Transition Planning only)
- Withdrawal Syndrome
- Wound debridement

### Acute Pediatrics

- Acetaminophen Overdose
- Acute Kidney Injury
- Anemia/Bleeding
- Antepartum
- Asthma
- Brief Unresolved Unexplained Event
- Bronchiolitis
- Carbon Monoxide Poisoning
- Cellulitis
- Croup
- Cystic Fibrosis
- Dehydration/Gastroenteritis
- Diabetic Ketoacidosis (DKA)
- Diabetes Mellites (DM)
- Electrolyte/Mineral Imbalance
- Epilepsy
- Extended Stay
- Failure to Thrive
- General Medical
### Medical Necessity

- General Trauma
- Hematology/Oncology: Chemotherapy
- Hematology/Oncology: Acute Leukemia
- Hematology/Oncology: Brain Malignancy/Metastasis
- Hematology/Oncology: Hemolytic Uremic Syndrome
- Hematology/Oncology: Malignant Disease
- Hematology/Oncology: Tumor Lysis Syndrome
- Hip Arthrotomy
- Hyperbilirubinemia
- Hypertensive Disorder in Pregnancy
- Hypoglycemia
- Infection: Central Nervous System (CNS)
- Infection: Endocarditis
- Infection: General
- Infection: Gastrointestinal/Genitourinary/Gynecology
- Infection: Meningitis
- Infection: Musculoskeletal
- Infection: Pneumonia
- Infection: Pyelonephritis
- Infection: Sepsis
- Infection: Skin
- Labor & Delivery
- Nursery
- Pancreatitis
- Postpartum Complications After Discharge
- Quality Indicator Checklist
- Rhabdomyolysis or Crush Syndrome
- Sickle Cell Crisis
- Transition Plan (Continued Stay and Transition Planning only)
- Withdrawal Syndrome
- Wound debridement

### Behavioral Health

- Adult and Geriatric Psychiatry
- Child and Adolescent Psychiatry
- Electroconvulsive Therapy: Adolescent
- Electroconvulsive Therapy: Adult/Geriatric
- Substance Abuse Disorders
### Medical Necessity
- Applied Behavior Analysis for Autism Spectrum Disorder
- Electroconvulsive Therapy Adolescent
- Electroconvulsive Therapy Adult/Geriatric
- Neurobehavioral Status Exam
- Neuropsychological Testing
- Neuropsychological Testing: Pediatric
- Pharmacogenomic Testing for Psychotropic Medication Drug Response
- Psychological Testing
- Stereotactic Introduction: Subcortical Electrodes

### Durable Medical Equipment (effective July 2, 2020)
- Cardioverter Defibrillator Wearable (WCD)
- Continuous passive motion devices (CPM), knee
- Continuous passive motion devices (CPM), upper extremity
- Hospital beds and cribs
- Insulin pump, ambulatory
- Orthoses, cranial remodeling
- Orthoses, lower extremity, knee
- Orthoses, lower extremity, knee ankle foot (KAFO) and ankle foot (AFO)
- Patient lift system
- Pneumatic compression devices
- Power operated vehicles (POV)
- Seat lift mechanism
- Secretion clearance devices
- Standing frames
- Support surfaces
- Wheel or wheelchairs, power assist
- Wheelchair, cushions or seating system
- Wheelchairs or strollers, pediatric
- Wheelchairs, manual
- Wheelchairs, power

### Home Care
- Adult and Pediatric

### Long Term Acute Care (LTAC)
- Medically Complex
- Respiratory Complex
- Transition Plan
- Ventilator Weaning
- Wound/Skin
<table>
<thead>
<tr>
<th>Medical Necessity</th>
<th>Procedures (effective July 2, 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Angiogram coronary +/- left heart catheterization</td>
</tr>
<tr>
<td></td>
<td>Angiogram coronary +/- left heart catheterization, cardiac</td>
</tr>
<tr>
<td></td>
<td>Angiogram coronary +/- right heart catheterization</td>
</tr>
<tr>
<td></td>
<td>Angiogram coronary +/- right heart catheterization, cardiac</td>
</tr>
<tr>
<td></td>
<td>Arthroscopically assisted surgery, knee (adult)</td>
</tr>
<tr>
<td></td>
<td>Arthroscopy, diagnostic, +/- synovial biopsy, knee</td>
</tr>
<tr>
<td></td>
<td>Arthroscopy, knee (adult)</td>
</tr>
<tr>
<td></td>
<td>Bone graft and implantable stimulator fracture nonunion</td>
</tr>
<tr>
<td></td>
<td>Cardiac catheterization and coronary angiography</td>
</tr>
<tr>
<td></td>
<td>Catheterization left heart with coronary angiogram</td>
</tr>
<tr>
<td></td>
<td>Catheterization right heart with coronary angiogram</td>
</tr>
<tr>
<td></td>
<td>Cochlear implantation (adult, pediatric)</td>
</tr>
<tr>
<td></td>
<td>Electrical stimulation of the spine as an adjunct to spinal fusion procedures</td>
</tr>
<tr>
<td></td>
<td>Endoscopy, upper gastrointestinal (GI)</td>
</tr>
<tr>
<td></td>
<td>Endovenous ablation, varicose veins</td>
</tr>
<tr>
<td></td>
<td>Hearing aid, middle ear</td>
</tr>
<tr>
<td></td>
<td>Left atrial appendage closure, percutaneous</td>
</tr>
<tr>
<td></td>
<td>Ligation/excision, varicose veins, +/- Strisping</td>
</tr>
<tr>
<td></td>
<td>Panniculectomy, abdominal</td>
</tr>
<tr>
<td></td>
<td>Reduction mammaplasty for breast related symptoms</td>
</tr>
<tr>
<td></td>
<td>Reduction mammaplasty, female (adult and adolescent); male (adult and adolescent)</td>
</tr>
<tr>
<td></td>
<td>Rhinoplasty</td>
</tr>
<tr>
<td></td>
<td>Sclerotherapy, varicose veins</td>
</tr>
<tr>
<td></td>
<td>Spinal cord stimulator (SCS), insertion</td>
</tr>
<tr>
<td></td>
<td>Stereotactic introduction subcortical or cortical electrodes</td>
</tr>
<tr>
<td></td>
<td>Total joint replacement (TJR), hip</td>
</tr>
<tr>
<td></td>
<td>Total joint replacement (TJR), hip, removal and replacement</td>
</tr>
<tr>
<td></td>
<td>Total joint replacement (TJR), knee, removal and replacement,</td>
</tr>
<tr>
<td></td>
<td>Total joint replacement (TJR), knee, unicodylar or patellofemoral knee replacement</td>
</tr>
<tr>
<td></td>
<td>Total joint replacement (TJR), unicodylar knee replacement</td>
</tr>
<tr>
<td></td>
<td>Transcatheter aortic valve implantation for aortic stenosis</td>
</tr>
<tr>
<td></td>
<td>Transcatheter aortic valve replacement (TAVR)</td>
</tr>
<tr>
<td></td>
<td>Vagus nerve stimulation (adult, pediatric)</td>
</tr>
</tbody>
</table>
### Medical Necessity

- Wireless pulmonary artery pressure monitoring

### Rehabilitation

- Amputation, lower extremity rehabilitation (adult, adolescent, school age)
- Amputation, upper extremity rehabilitation (adult, adolescent, school age)
- Cardiac rehabilitation (adult)
- Carpal tunnel syndrome rehabilitation (adult)
- Cerebrovascular accident rehabilitation (adult)
- DeQuervain’s tenosynovitis rehabilitation (adult)
- Fractures, lower extremity (adult, adolescent, school age)
- Fractures, upper extremity rehabilitation (adult, adolescent, school age)
- General deconditioning rehabilitation (adult)
- Habilitation (adult, adolescent, school age)
- Habilitation criteria
- Instability dislocation shoulder rehabilitation (adult)
- Ligamentous injury ankle rehabilitation (adult, adolescent, school age)
- Ligamentous injury knee rehabilitation (adult, adolescent, school age)
- Lymphedema rehabilitation (adult)
- Maintenance therapy rehabilitation (adult)
- Meniscal injury knee rehabilitation (adult, adolescent, school age)
- Multiple sclerosis rehabilitation (adult)
- Osteoarthritis hip rehabilitation (adult)
- Osteoarthritis rehabilitation, knee (adult)
- Osteoarthritis rehabilitation, shoulder (adult)
- Pain syndromes rehabilitation (adult, adolescent)
- Pediatric rehabilitation criteria
- Pelvic floor rehabilitation
- Pulmonary rehabilitation (adult)
- Rotator cuff disorders rehabilitation (adult, adolescent, school age)
- Soft tissue disorders knee rehabilitation (adult, adolescent, school age)
### Medical Necessity

- Soft tissue disorders rehabilitation, foot and ankle (adult adolescent, school age)
- Soft tissue disorders, rehabilitation (adult)
- Spinal disorders rehabilitation, cervical (adult)
- Spinal disorders rehabilitation, lumbar (adult, adolescent, school age)
- Sprain wrist rehabilitation (adult, adolescent, school age)
- Strain low back rehabilitation (adult, adolescent, school age)
- Strain neck rehabilitation (adult, adolescent, school age)
- Tendon injury hand rehabilitation (adult, adolescent, school age)
- Tendon rupture achilles rehabilitation (adult)
- Thoracic outlet syndrome rehabilitation (adult, adolescent, school age)
- Traumatic brain injury rehabilitation (adult)
- Trigger finger rehabilitation (adult)
- Ulnar neuropathy rehabilitation (adult, adolescent, school age)

### Specialty Rx Non-Oncology

- AbobotulinumtoxinA
- Aflibercept
- Alpha 1 Proteinase Inhibitor
- Bevacizumab Intravitreal
- Factor IX (Alphanine SD)
- Factor IX (Bebulin VH, Profilnine SD)
- Factor IX (Benefix, Rixubis)
- Factor VIII (Advate)
- Factor VIII (Alphanate)
- Factor VIII (Hemofil M)
- Factor VIII (Humate-P)
- Factor VIII (Wilate)
- Factor VIII (Xyntha)
- Factor VIII or IX (Feiba NF)
- Factor XIII (Corifact)
- Hydroxyprogesterone caproate
- IncobotulinumtoxinA
- Lanreotide
- Octreotide acetate (Sandostatin LAR Depot)
### Medical Necessity

- Octreotide acetate (Sandostatin)
- OnabotulinumtoxinA
- Ranibizumab
- Reslizumab
- Rho(D) immune globulin (Rhophylac)
- Rho(D) immune globulin (WinRho)
- RimabotulinumtoxinB

### Specialty Rx Oncology

- Plerixafor
- Rolapitant injection
- Zoledronic acid

### Subacute/Skilled Nursing Facility

- Maintenance Therapy

### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/16/19</td>
<td>New administrative guideline, approved August 30, 2019, effective January 1, 2020, developed to aid in navigation to InterQual® clinical criteria for use in the individual market.</td>
</tr>
<tr>
<td>10/22/19</td>
<td>Minor update, the policy was corrected to remove drugs that will not be addressed using InterQual criteria. These had been added in error.</td>
</tr>
<tr>
<td>11/21/19</td>
<td>Interim Review, approved November 12, 2019, effective February 21, 2020. Added rehabilitative services to be reviewed using InterQual as listed; considered medically necessary when criteria are met.</td>
</tr>
<tr>
<td>12/01/19</td>
<td>Minor update, the policy was corrected to remove additional drugs that will not be addressed using InterQual criteria. These had been added in error.</td>
</tr>
</tbody>
</table>
| 04/01/20   | Interim Review, approved March 10, 2020. The following changes are **effective July 2, 2020**, following provider notification. Services within durable medical equipment and procedures were added to those reviewed for medical necessity using InterQual® criteria for dates of service July 2, 2020, and after. The following policies are no longer effective after that date: 1.01.10, 1.01.11, 1.01.15, 1.01.18, 1.01.30, 1.01.501, 1.01.519, 1.01.520, 1.01.527, 1.03.501, 2.01.40, 2.01.505, 2.01.533, 2.02.09, 2.02.26, 2.02.30, 2.02.506, 2.02.507, 6.01.25, 7.01.05, 7.01.07, 7.01.20, 7.01.107, 7.01.108, 7.01.109, 7.01.132, 7.01.138, 7.01.143, 7.01.503, 7.01.508, 7.01.516, 7.01.519, 7.01.521, 7.01.522, 7.01.523, 7.01.533, 7.01.542, 7.01.546, 7.01.549, 7.01.550, 7.01.551, 7.01.554, 7.01.555, 7.01.558, 7.01.560, 7.01.570, 7.01.573, 7.01.63, 7.01.84, 7.01.87, 7.01.95, 7.03.01, 7.03.09, 7.03.09, 7.03.09, 7.03.09.
<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/06/20</td>
<td>Interim Review, approved May 5, 2020. Corrections made: Policies 2.02.09, 7.01.07, 7.01.87, 7.01.95, 7.01.554, 7.03.09, 7.03.11 and 9.03.01 along with corresponding InterQual subsets removed; policies 8.01.529 and 8.01.532 added (subsets were listed but titles were inadvertently not included in reference policies). Autologous stem cell transplant subset added; it was left out in error.</td>
</tr>
<tr>
<td>06/09/20</td>
<td>Interim Review, approved June 9, 2020. Correction made: policies 2.01.40, 2.01.505, 6.01.25, 7.01.107, 7.01.108, 7.01.109, 7.01.138, 7.01.508, 7.01.516, 7.01.522, 7.01.533, 7.01.542, 7.01.551, 7.01.555, 7.01.560, 7.01.570, 7.03.01, 7.03.509, 8.01.11, 8.01.15, 8.01.17, 8.01.21, 8.01.22, 8.01.29, 8.01.30, 8.01.521, 8.01.529, 8.01.532 along with corresponding InterQual subsets removed.</td>
</tr>
<tr>
<td>06/25/20</td>
<td>Interim Review, approved June 25, 2020. Removed policy 2.02.30 – this policy will remain active and InterQual will not replace this review criteria on July 2, 2020.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2020 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy only applies to Individual plans.
Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5952, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room S09F, HHH Building

Getting Help in Other Languages

This Notice has Important Information. If you need these services, contact the Civil Rights Coordinator.

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action before a deadline to keep your health coverage or to avoid costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

Oromo (Cushite):
Lakkoofta biibliya 800-722-1471 (TTY: 800-842-5357) ti biibliya.

Français (French):
Appelez le 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):

Hmoob (Hmong):

Hmoob (Hmong):

Iloko (Ilocano):
Dayttoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Dayttoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyono yeti coverage babaen iti Premera Blue Cross. Dayttoy ket mabalin dagiti importante a pelta iti dayttoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalainedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti dayttoy nga impormasion ken tulong iti bukodyo a pasasago nga awan ti bayadanyo. Tumawag ti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente.
Chiamà 800-722-1471 (TTY: 800-842-5357).
Premera Blue Cross (TTY: 800-842-5357).