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ADMINISTRATIVE GUIDELINE – 10.01.531

InterQual Criteria: Services Reviewed for Medical Necessity

Effective Date:	Nov. 1, 2024	RELATED MEDICAL POLICIES:
Last Revised:	Oct. 21, 2024	None
Replaces:	N/A	

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ADMINISTRATIVE GUIDELINE | HISTORY

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Introduction

The Plan uses InterQual criteria to review certain services 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, and procedures.

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.

Administrative Guideline

Medical Necessity	
The following services may be considered medically necessary when criteria are met using InterQual criteria:	
Module	**Service**
Level of Care	• Acute adult • Acute pediatric • Long-term acute criteria

Medical Necessity	
	• Rehabilitation criteria
Behavioral Health	• Adult and Geriatric Psychiatry • Child and Adolescent Psychiatry • Substance Abuse Disorders

History

Date	Comments
04/01/20	New administrative guideline, approved March 10, 2020, and effective July 2, 2020. This guideline has been developed to provide transparency into what procedures are reviewed using InterQual criteria. The InterQual criteria listed in this guideline replaces the following medical policies: 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, 2.02.09, 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, 7.01.521, 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, 7.03.11, 7.03.509, 8.01.11, 8.01.15, 8.01.17, 8.01.21, 8.01.22, 8.01.29, 8.01.30, 8.01.36, 8.01.521, 9.03.01– these policies are deleted effective for dates of service July 2, 2020, and after.
05/06/20	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.
06/09/20	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.
06/25/20	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.
11/01/20	Interim Review, approved Oct. 13, 2020. Policy updated with the removal of outpatient procedures and DME which will no longer be in effect as of Feb. 5, 2021, following provider notification. These procedures are now reviewed using medical policies.
04/01/21	Annual Review, approved March 23, 2021. No changes.
08/01/22	Annual Review, approved July 25, 2022. Guideline reviewed; no changes made.
11/01/23	Annual Review, approved October 9, 2023. Guideline reviewed; no changes made.

Date	Comments
11/01/24	Annual Review, approved October 21, 2024. Guideline reviewed with no changes.

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). ©2024 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 does not apply to Medicare Advantage.