Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Blue Cross and BCN Local Rules for 2022 (non-behavioral health)

Modifications of InterQual® acute care criteria

For Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠

Effective March 1, 2022

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In this document

Condition-specific Local Rules for acute medical admissions of adults 1
  Exceptions 1
  Documentation requirements 2
  Conditions this applies to 2
  How determinations will be made 2
Medicare "two midnight" rule 3

In applying InterQual criteria to various services, Blue Cross Blue Shield of Michigan and BlueCare Network have adopted Local Rules. These Local Rules are modifications of the InterQual criteria and apply to all Blue Cross and BCN members statewide whose utilization is managed by Blue Cross and BCN Utilization Management departments.

This document outlines the Local Rules, or modifications of InterQual criteria, for acute care adult services.

Note: For members admitted prior to March 1, 2022, the following 2021 Local Rules apply:

- Blue Cross modifications of InterQual criteria, effective Aug. 2, 2021
- BCN's Local Rules effective Aug. 2, 2021

Condition-specific Local Rules for acute medical admissions of adults

For certain conditions, authorization requests for acute medical admissions should be submitted only after the member has spent two days in the hospital. Once two days has elapsed, the facility can submit the request to authorize an inpatient admission on the third day.

Note: The documentation submitted must include clinical information from days 1, 2 and 3 of the stay.

Exceptions

Requests can be submitted prior to completion of the two-day period, along with all clinical documentation, in these circumstances:

- When a member is receiving intensive care services that require a critical care setting

  Note: Documentation must support and meet criteria for the critical level of care.
- When member has expired during the admission, prior to day 3
- When member has left against medical advice prior to day 3
- For preservice admissions (prospective admissions)
- For hospital-to-hospital transfers for a higher level of care that occur prior to day 3
- For all pediatric admissions

Documentation requirements

Submission of the request on day 3 must include documentation of clinical status and interventions as well as physician/RN documentation that demonstrates that the InterQual criteria have been met at the time the request is submitted. Documentation must include clinical information from days 1, 2 and 3 of the stay.

Conditions this applies to

This applies to members with the following conditions:

- Allergic reaction
- Anemia
- Arrhythmia, atrial
- Asthma
- Chest pain
- COPD
- Dehydration
- Deep vein thrombosis
- Diabetic ketoacidosis
- Headache
- Heart failure
- Hypertensive urgency
- Hypoglycemia
- Intractable low back pain
- Nausea / vomiting
- Nephrolithiasis
- Pneumonia
- Pulmonary embolism
- Skin and soft tissue infection
- Syncope
- Transient ischemic attack

How determinations will be made

Once the request has been received, Blue Cross and BCN will conduct a medical necessity review based on the clinical documentation submitted. InterQual criteria will be applied based on the clinical documentation received:

- Episode Day 1 criteria will be applied for the exceptions listed above.
- Episode Day 3 criteria will be applied, using the clinical information submitted for day 3, for all other requests:

- If Episode Day 3 InterQual criteria are met based on the Blue Cross and BCN review of the documentation, the authorization request will be approved.
- If Episode Day 3 InterQual criteria aren't met based on the Blue Cross and BCN review of the documentation, the authorization request will be sent to the plan medical director for review. It will include the clinical information that was submitted for days 1, 2 and 3, so the medical director can view the full clinical picture.
- If the member hasn't been in the hospital for two days, doesn't meet criteria for the critical level of care or doesn't fit into one of the other exception categories listed above, Blue Cross and BCN will request that the facility wait until day 3 to send additional information about the member's condition. We'll make the request through the Case Communication field in the e-referral system or by calling the facility, or both.

After receiving the request from the hospital on the third day, Blue Cross and BCN will do the following:

- If the facility sent additional clinical information and it meets Episode Day 3 criteria, we'll approve the request.
- If the facility hasn't sent additional clinical information or has sent additional clinical information but it doesn't meet Episode Day 3 criteria, we'll refer the request to the medical director for review.

For requests that are nonapproved, Blue Cross and BCN will reimburse as observation. The hospital will need to submit a claim for observation reimbursement.

Medicare "two midnight" rule

The BCN Advantage and Medicare Plus Blue clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures and the "two midnight" rule.

Follow the BCN Advantage and Medicare Plus Blue referral and clinical review process.

Observation doesn't define clinical care, but rather describes the billing and payment method for a short stay in the hospital.