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 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. You must provide clinical documentation that demonstrates that the InterQual criteria have been met at the time you submit the request.

Exception: When a member is receiving intensive care services that require a critical care setting, you can submit the request prior to completion of the two-day period, along with all clinical documentation supporting the critical level of care.

Conditions this applies to

This applies to members with the following conditions:

- Allergic reaction
- Deep vein thrombosis
- Nausea / vomiting

- Anemia
- Arrhythmia, atrial
- Asthma
- Chest pain
- COPD
- Dehydration
- Diabetic ketoacidosis
- Headache
- Heart failure
- Hypertensive urgency
- Hypoglycemia
- Intractable low back pain
- 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 you submitted. InterQual criteria will be applied based on the member's condition at the time the clinical documentation is received:

- If InterQual criteria are met, the authorization request will be approved.
- If InterQual criteria aren't met, the authorization request will be sent to the plan medical director for review.
- If the member hasn't been in the hospital for two days and isn't in a critical care setting, Blue Cross and BCN will request that the facility wait until the member has been in the hospital for two days 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 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 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 (two or fewer calendar days) in the hospital.

Guidelines for surgery and procedures in the inpatient setting, adult and pediatric

Facilities are required to submit a prior authorization request for all acute hospital admissions and surgical procedures. All hospital admission prior authorization requests must be made through the e-referral system.

Procedures that are included on InterQual's inpatient listing are either:

- Appropriate for the inpatient setting based on InterQual procedures criteria
- Appropriate for the inpatient setting but not addressed by InterQual procedures criteria

Due to variations in practice, surgical procedures marked with an asterisk may be performed as inpatient or outpatient.

The attending surgeon continues to determine the best level of care for his or her patient based on the procedure and its urgency, as well as on the patient's stability, comorbidities and likelihood of complications.

BCN Advantage and Medicare Plus Blue use the Centers for Medicare & Medicaid Services inpatient list for determination of procedures appropriate for the inpatient setting.

Blue Cross Blue Shield of Michigan's medical policies and payment policies apply to procedures that are investigational or experimental.

Note: The postoperative management of outpatient surgical procedures is not considered by Blue Cross to be an observation level of care and should not be billed as such. Blue Cross requires prior authorization for postoperative management that's provided in the inpatient setting.