Optum

InterQual® Specialty Referral Criteria

2025 Review Process

Introduction

As part of the InterQual® Care Planning family of products, InterQual® Specialty Referral Criteria provide healthcare organizations with evidence-based clinical decision support for referral to specialists. Healthcare providers and reviewers use the criteria to make effective utilization decisions at the point of care or during the preauthorization process.

Note: The criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of health care services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.

InterQual® content contains references to patient sex or gender. Depending on the context, these references may refer to either genotype or phenotype. At the individual patient level, a variety of factors, including but not limited to gender identity and gender affirmation via surgery or hormonal treatment, may affect the applicability of some InterQual® Criteria. This occurs most often with genetic testing and some procedures that require the presence of specific anatomy. For the purpose of these criteria, references to Male and Female are based on sex assigned at birth, unless otherwise defined. InterQual users should carefully consider patient genotype and anatomy when appropriate.

Notes

The following note types provide additional information and instruction in the criteria:

- **Informational notes** provide information regarding best clinical practice, new clinical knowledge, explanations of criteria rationale, definitions of medical terminology, medical policy decisions, and current literature references. The notes in the criteria are specific to each indication or criteria point.
- **Mandatory notes** provide information you must read while performing a review. The criteria have two types of mandatory review notes:
  - **Medical Review (MDR) Notes** – clinical circumstances where secondary review is required.
  - **Reviewer Instructional Notes (RIN)** – special instructions to the reviewer regarding criteria application
- **Purpose of Specialist Involvement (PSI) notes** identify the purpose of the specialty care sought and the appropriate specialist for that particular condition. PSI notes may be provided at the indication or criteria point level, depending on the clinical circumstance. The subset notes include a summary of the PSI notes presented in a table with the corresponding indication and criteria number. For each distinct review there is only one PSI note linked to the criteria that is selected. If the PSI information is provided at the indication level, it applies to all the underlying criteria elements. The purpose of specialist involvement is categorized into four groups:

- **Diagnosis** pertains to situations where the diagnosis is not known or not confirmed. The patient may be referred for a procedure (e.g., bronchoscopy), further complex testing, or review and synthesis of available clinical data. Once the diagnosis is established, care of the patient is returned to the primary care provider. The suggested number of visits for a diagnostic referral range from 3 to 5 visits.
- **Limited Management** pertains to situations in which a diagnosis has been established, but referral is necessary because initial therapeutic interventions have failed or are not available at the primary care level. A referral for limited management could be for a procedure (e.g., colonoscopy), for optimization of pharmacologic therapy, or for institution of high-risk or complex treatments. The suggested number of visits for a limited management referral ranges from 3 to 5 visits.
- **Periodic Assessment** is warranted for preventive interventions and monitoring of patients with diseases that are stable or in remission. For example, a referral for periodic assessment might include an annual or biannual ophthalmologic examination in the diabetic patient, or an annual evaluation by an oncologist for the patient with a malignancy in remission. The frequency of assessment is suggested in some instances, and in others, it is a matter for clinical judgment and influenced by the clinical condition.
- **Co-Management** is appropriate for patients with an illness and morbidity of sufficient complexity that ongoing specialty treatment is justified. For example, co-management with a pulmonologist is recommended for patients with asthma requiring chronic corticosteroid use.

How to conduct a medical review

During a medical review, you use the criteria as a decision support tool to assess the medical appropriateness of a specialty referral. Although labeled as a “Medical Review” in the software, this type of review is also known as a primary review. This first-level review typically involves a non-physician reviewer, who uses the criteria to determine if the request is appropriate or if the review requires secondary review.

Conduct a medical review as follows:

Step 1: Select a subset

You can search for a subset using one or more of the following methods:

- **By category** — categories organize specific, logical clinical groupings for the conditions for referral, for example, Cardiovascular Disorders or Dermatologic Disorders. If you are uncertain which category to select, select All Categories.
- **By keyword(s)** — keywords are words found in the subset name or alternate condition names.
- **By medical code(s)** — medical codes include codes such as ICD10-DM codes.

A subset is the specific reason for seeking specialty care. It may be:

- A symptom, for example, Cough, Unknown Etiology
- A condition, for example, Asthma
- Findings on physical examination, for example, Physical Examination Findings (Neurologic Disorders)
- Study results, for example, Imaging Study Abnormalities (Pulmonary Disorders)

This content is appropriate for adult patients only. Adult patients are defined as patients ≥ 18 years of age.

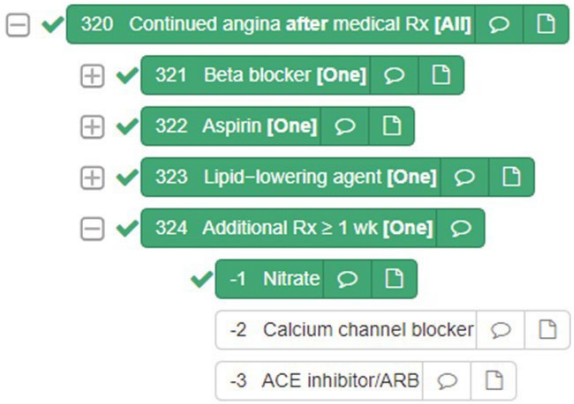
The subset notes include notes regarding alternate condition names. These notes provide a list of additional names for a condition in a subset, or additional conditions covered in the subset. For example, Causalgia or Reflex Sympathetic Dystrophy are alternate names that can be used for Complex Regional Pain Syndrome (CRPS).

Step 2: Complete the medical review

1. Choose the appropriate indication.
2. Select the criteria points that reflect the patient's condition based on the clinical scenario.
3. Apply the rules, beginning at the indication and following through all the associated criteria.
   - **Indications** are reasons why specialty care is requested. For example, Asthma with complication/comorbidity is one indication, or reason, for requesting a specialty intervention. Indications cover diagnoses, symptoms, or clinical findings that constitute possible reasons for specialist intervention. All indications are denoted with a number that ends in 00.
   - **Criteria points** are clinical statements that support indications and refer to test results, medications, symptoms, clinical findings, or medical management. A unique number identifies each criteria point, and they are organized in a nested decision tree. Criteria points address elements related to the evaluation and management of the patient. They serve to validate the problem identified in the indication or confirm that appropriate diagnostic or therapeutic interventions have been attempted prior to obtaining approval for the requested specialist intervention.

     The criteria points may include the results of diagnostic tests or may just indicate that the results are available. "Results available" indicates that a test must be performed, and the results be available for the specialty referral visit, but a specific value does not need to be recorded prior to the visit.
   - **Criteria rules** show you how many (e.g., ONE, BOTH, ALL) of the next level criteria a reviewer must select to fulfill the rule. To meet the criteria and determine that specialty intervention is appropriate, the reviewer must select criteria points as the rules specify. Rules are presented in brackets and bold print.

In some cases, the criteria point at the same level as the rule, in addition to the underlying criteria, must be applicable for the criteria to be met. This is called a selectable rule (or checkable rule) and occurs when both the criteria point at the same level as the rule and the underlying criteria are clinically true. A transition word (for example, and, after) indicates that the criteria is selectable.



Note: Urgent conditions may not require preauthorization. A review to determine the appropriateness of the intervention is generally performed following the intervention. If there is adequate time to complete a review before performing the intervention, the urgent criteria may also be used for a prospective review.

Software note: In InterQual InterQual® Cloud Solutions, urgent conditions are indicated by a ⚠ symbol. In InterQual® Review Manager, urgent conditions are indicated by ♦ symbol.

Step 3: Take action based on review findings

Take the appropriate action based on the review findings.

For these review findings:	Do this:
Primary review: Criteria Met	Approve the request
Primary review: Criteria NOT Met	• Obtain additional information from the requesting physician to complete the review • If the additional information satisfies the primary review, the request may be approved • If the additional information does not satisfy the review, refer for secondary review. (NOTE: Secondary review is required when the patient presents with the clinical scenario identified in the Medical Review Note (MDR) • If no further information is available, refer the case for secondary review

Multiple specialist referrals

In cases when referral to more than one specialist is appropriate; the PSI note will identify all potential specialists. Selection of the appropriate specialist(s) listed in the note is based on the clinical presentation of the patient. There may be overlapping expertise among specialists and one of the listed specialists can be chosen. For example, a patient with a cough of unknown etiology may be referred to a Pulmonologist or Otolaryngologist. There are times that multi-specialty involvement is warranted. For example, a patient with a lung malignancy may be referred to a Surgeon, Radiation Oncologist, and Oncologist.

Step 4: Approve the recommended procedure(s) or refer for a secondary review

Outcome referral reasons

Referral reasons vary from product to product and display based on the selected outcome. Referral reasons identify reasons why the proposed request does or does not meet medical necessity or medical

appropriateness. Examples include criteria issues, such as no criteria to cover indication/procedure and provider issues, such as test results incomplete.

Software note: In InterQual® Cloud Solutions, an organization can add as many outcomes and reasons as they require to meet their needs. In Review Manager, an organization can add their own specific referral reasons and create unique outcome groups to delete or hide existing referral reasons.

Secondary review

Secondary review determines the appropriateness of a request (e.g., imaging or diagnostic study, procedure, equipment) when it is not supported by criteria on primary review. Organizational policy should dictate the extent to which secondary review is performed to render a review outcome.

When is secondary review appropriate?

The following scenarios may indicate that a secondary review is appropriate:

- **Criteria subset not listed**. Only the more common specialty referral conditions are included in criteria. InterQual content does not currently cover this request. This does not mean that the request is inappropriate, but that it is less common or emerging and may be sent for secondary review.
- **Indications not listed**. An indication for the request is not listed.
- **Criteria not available for the age group**. The criteria do not cover the age group requested. (These criteria are for adult patients only.)
- **Medical Review (MDR) note indicates the need for secondary review**. Some indications or criteria contain Medical Review Notes (MDR) that require, in the presence of certain circumstances, that the request be sent for secondary review.
- **Criteria not met**. When the given indication is listed, but the required criteria are not fulfilled, the case requires secondary review.
- **Patient choice and preference**. The criteria delineate reasonable courses for most patients. Some patients choose or prefer different prerequisite therapies or testing; these cases require secondary review.

Who is responsible for completing a secondary review?

A secondary review may be completed by a supervisor, medical practitioner, subject matter-expert or designated clinician. A medical practitioner is not required to perform a secondary review; however, some regulatory requirements specify that only a physician can issue a final non-determination (denial) decision.

Secondary review steps

1. The secondary reviewer determines medical necessity based on review of the medical record; discussions with members of the interdisciplinary team (e.g., nursing staff, the discharge planner, therapists, and the attending medical practitioner), and clinical knowledge and judgment.

   Note: The secondary reviewer is not required to but may choose to apply InterQual® Criteria when completing a secondary review. Best practice would include reviewing the results of the primary review to ensure internal agreement in criteria application.

   To determine medical necessity, it may be appropriate for the secondary reviewer to consider other factors in the determination, such as:

   – Age
   – Co-morbid conditions (e.g., medical, substance use, and psychiatric disorders)

  - Treatment response and patient engagement
  - History of non-adherence and poor health outcomes
  - Availability (e.g., a drug not available in the formulary or an imaging test/procedure not available on-site)
  - Other organization- or patient-specific factors

    Tip: A primary reviewer can assist the secondary review process by including the outcome of the InterQual review, as well as documentation that could support these additional factors

2. Determine the review outcome:
   - If the secondary reviewer agrees with the request, approve.
   - If the secondary reviewer does not agree with the request, discuss the optimal alternate management for this patient with the requesting provider.
   - If the requesting provider does not agree with the secondary reviewer's determination, a specialist may become involved in the review process.
3. Document the review outcome.

Reference materials

Reference materials are provided with the criteria and should be used to assist in the correct interpretation of the criteria:

- **Abbreviations and symbols:** Defines acronyms, abbreviations and symbols used in the criteria.
- **Bibliography:** Provides references cited in the clinical content.
- **Clinical revisions:** Provide details of changes to InterQual® Criteria.
- **Drug list:** Categorizes drug names and classes mentioned within the criteria.
- **InterQual® clinical development process:** Describes the comprehensive development process for InterQual® clinical content.

Additional resources

InterQual® Resource Center

The InterQual® Resource Center is a central location for the most up-to-date InterQual clinical documentation and resources.

The Resource Center provides access to:

- **What's new:** Includes release highlights for each of the InterQual® Criteria modules included in a content release.
- **Clinical revisions:** Includes the clinical revisions for the current InterQual® Criteria year and two years prior.
- **Clinical resources:** Includes information such as the Knowledge Articles, Known Issues List, and more.
- **Webinars:** Includes the Increase Your IQ educational webinar recordings.
- **Additional resources:** Includes access to resources such as the InterQual® release schedule, the InterQual® Learning Source, and Download Connect.

Customer Care Hub

Customer Care Hub is a web portal that provides the ability to submit, update, and view support case details and status.

To obtain a user ID and password, from the Customer Care Hub Welcome page, select Register.