INTERQUAL® DURABLE MEDICAL EQUIPMENT CRITERIA
REVIEW PROCESS
ORGANIZATION

InterQual Durable Medical Equipment (DME) criteria are organized according to General and Senior categories. General criteria are clinically appropriate criteria for adult and/or pediatric populations. Senior criteria are clinically appropriate criteria aligned with Medicare coverage guidelines.

CARE PLANNING COMPONENTS

Categories organize the criteria based on population. DME criteria categories serve two distinct populations, General and Senior.

The criteria subset is the medical equipment that is being reviewed (e.g., Hospital Beds).

Equipment/Indications identify the specific types of medical equipment or the reasons (e.g., clinical diagnosis) for the requested medical equipment and are denoted numerically by ending in "00."

Criteria points are clinical statements that refer to diagnoses, test results, clinical symptoms and/or findings, medical or clinical management, or equipment-specific features. 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.

Criteria rules specify how many (ONE, BOTH, ALL, ONE OR MORE, etc.) of the next level criteria a reviewer must select to fulfill the rule. Rules are presented in upper case letters and in parentheses.

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. Selectable rules are usually designated by "and" preceding the rule.

Example:

100 Depth shoes (A5500) [All] (3, 4, 5)
   110 Diabetes mellitus and [One or More] (9)
      111 Partial/total amputation of foot by Hx (10)
      112 Foot ulcer by Hx (11, 12)
      113 Preulcer callus by Hx
      114 Peripheral neuropathy and callus formation (13)
      115 Foot deformity (14)
      116 Evidence of poor circulation (15)
   120 Receiving physician directed comprehensive diabetes management (16)
   130 Shoes fitted by qualified specialist (17)

In this example the criteria point @ 110 is a selectable rule. To fulfill these criteria, the patient must have diabetes mellitus and at least one of the subsequent conditions (e.g., Partial/total amputation of foot by Hx, Foot ulcer by Hx, etc).

Notes provide information about a particular piece of equipment, explanations of criteria rationale, definitions of medical terminology, information about a clinical condition, and references to support the content.
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PRIMARY REVIEW

The reviewer uses the criteria as a screening tool to determine if the equipment request is appropriate or if the case requires secondary review.

Primary Review Steps:
1. Choose the category (select the category based on the organizational policy of the healthcare system).
2. Identify the criteria subset that contains the requested medical equipment.
3. Choose the equipment or indication that best reflects the requested equipment or patient’s condition.
   - Apply the rules, begin at the equipment/indication and follow through all the associated criteria.
   - Read the notes to obtain additional information pertinent to the review.
4. Select the criteria points that reflect the patient’s condition or medical needs based on available information.
5. Determine the review decision or outcome.
6. Record the review action.

The action that follows depends on whether the review criteria were met, as shown in this table.

<table>
<thead>
<tr>
<th>For these Primary Review findings</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Met</td>
<td>• Approve the request.</td>
</tr>
</tbody>
</table>
| 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 and assign a referral code to the review.  
                                   | • If no further information is available, refer the case for secondary review and assign a referral code.  
                                   | • If all information is available and no additional information is needed to complete the review, refer for secondary review and assign a referral code to the case. |

Referral Codes

Referral Codes represent reasons the proposed request does not meet appropriateness criteria. Organizations should develop a list of referral codes to use prior to implementing use of InterQual Criteria. Documentation of referral codes over time can lead to quality improvement initiatives and assist in business decisions.
**INTERQUAL® DURABLE MEDICAL EQUIPMENT CRITERIA REVIEW PROCESS**

**Practical Tips**

As you perform your review, record the following in order to gather additional information that may be useful if the case is sent to secondary review:

- Actual clinical findings. Avoid writing terms such as “normal” or “elevated” or “low.”
- Prior equipment history, planned therapies and the patient’s response, or lack of response, to those services/equipment.
- Discussions with caregivers and physicians.
- Questions or concerns for follow-up review.

**SECONDARY REVIEW**

A secondary review is indicated when a case does not meet criteria. A supervisor, specialist, or physician may conduct secondary review. It is a matter for organizational policy to determine the qualifications of the reviewers as well as the extent to which secondary review is performed in order to render a review outcome. The secondary reviewer determines the medical necessity of the equipment request based on review of the medical record, discussions with the provider or referring physician, and by applying clinical experience.

**When is a Secondary Review Appropriate?**

- **Criteria not met**
  When the given equipment or indication is listed, but the required criteria are not fulfilled, the case requires secondary review.

- **Criteria subset/equipment/indication not listed**
  Only the more common equipment or indications are included in the criteria. This does not mean that the request is inappropriate, but that the request requires secondary review.

- **Patient has comorbid conditions**
  The general state of a patient’s health may influence both the provider and the reviewer regarding the wisdom of providing a specific type of equipment. If there is any question regarding the appropriateness because of comorbid conditions, a secondary review is required.

- **Patient choice and preference**
  Patient choice or preference is always an issue in practice. The criteria delineate the majority of clinically appropriate indications for durable medical equipment.

**Secondary Review Process**

- In a secondary review, the action that follows the review depends on whether the review criteria were met, as shown in this table.

<table>
<thead>
<tr>
<th>For these review findings</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary review: Criteria Met</td>
<td>If the secondary reviewer agrees with the request for the equipment, approve.</td>
</tr>
<tr>
<td>Secondary review: Criteria NOT Met</td>
<td>If the secondary reviewer does not agree with the request, he or she discusses the optimal alternate management for this patient with the requesting provider. If the requesting provider does not agree with the secondary reviewer, a specialist may become involved in the review process.</td>
</tr>
</tbody>
</table>
Secondary Reviewer Decision Codes
Secondary Reviewer Decision Codes represent the decisions of the secondary review.

IMPORTANT: 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.