

For commercial members, Blue Cross Blue Shield of Michigan and Blue Care Network use the pertinent medical necessity criteria to make determinations on prior authorization requests for the services listed below.

For Medicare Advantage (Medicare Plus Blue and BCN Advantage) members, we make medical necessity decisions based on national coverage determinations, local coverage determinations, and other applicable coverage criteria in Medicare statutes and regulations to determine if an item or service is reasonable, necessary and coverable under Medicare. If such criteria are not fully established and as permitted by Medicare statutes and regulations, we may create internal coverage criteria. Blue Cross licenses InterQual[®] to assist in creating internal coverage criteria. If InterQual criteria are unavailable, we'll use our own medical policies, which have been developed in accordance with Medicare statutes and regulations and approved by the Blue Cross Utilization Management Committee.

To view medical necessity criteria:

- **InterQual criteria for various services:** [Sign up](#) or [log in](#) to One Healthcare ID view InterQual procedure criteria.
- **National Coverage Determinations and Local Coverage Determinations:** See the [Medicare Coverage Database](#)* for the most current NCDs and LCDs.
- **Medical policies:** Open our [Medical Policy Router Search](#) page on **bcbsm.com**. Enter a procedure code in the *Policy/Topic Keyword* field to search for the pertinent policy.

Preview questionnaires show the questions you'll need to answer within the questionnaire that opens in the e-referral system so you can prepare your answers ahead of time. For some services, more than one preview questionnaire is listed in the following table because either:

- A different questionnaire opens in the e-referral system based on the line of business.
- A trigger questionnaire opens in the e-referral system, after which an additional questionnaire opens.

In the following table, the Criteria source column specifies the criteria we use to make determinations on prior authorization requests for specific services.

Preview questionnaires and medical necessity criteria

For Medicare Plus BlueSM, BCN commercial and BCN AdvantageSM

Revised February 2026

Service	Requires prior authorization for			Related documents	Criteria source
	Medicare Plus Blue	BCN commercial	BCN Advantage		
Balloon ostial dilation	✓	✓	✓	Preview questionnaire	Balloon Dilation for Treatment of Chronic Sinusitis medical policy
Blepharoplasty and repair of brow ptosis	✓	✓	✓	Preview questionnaire	<ul style="list-style-type: none"> Blepharoplasty and Repair of Brow Ptosis medical policy Local Coverage Determination for Blepharoplasty, Blepharoptosis and Brow Lift (L34528)
Breast elastography		✓	✓	Preview questionnaire	Breast Elastography – Ultrasound or Magnetic Resonance
Breast implant management		✓		Preview questionnaire	Reconstructive Breast Surgery/Management of Breast Implants medical policy
			✓	Preview questionnaire	Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051)
Breast reconstruction		✓		Preview questionnaire	Reconstructive Breast Surgery/Management of Breast Implants medical policy

Preview questionnaires and medical necessity criteria

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Breast reduction		✓		Preview questionnaire	Breast Reduction for Breast-Related Symptoms medical policy
			✓	Preview questionnaire	Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051)
Cosmetic or reconstructive surgery		✓		Preview questionnaire	Cosmetic and reconstructive surgery medical policy
Dental general anesthesia or dental services, trigger		✓		Preview questionnaire	Not applicable
Dental general anesthesia		✓		Preview questionnaire	Dental General Anesthesia medical policy
Dental services		✓		Preview questionnaire	<ul style="list-style-type: none"> • Immediate Repair of Trauma to Natural Teeth medical policy • Dental General Anesthesia medical policy • Oral Surgery medical policy
Endoscopic bypass		✓	✓	Preview questionnaire	Gastric Bypass Surgery for Gastroparesis
Endovascular intervention, peripheral artery	✓		✓	Preview questionnaire	<ul style="list-style-type: none"> • InterQual Procedures Adult Criteria, Endovascular Intervention, Peripheral Artery • Local Coverage Determination for Non-Coronary Vascular Stents (L35998)
Enteral nutrition		✓		Preview questionnaire	Enteral Nutrition medical policy

Enteral nutrition – specialized formula			✓	Preview questionnaire	Enteral Nutrition CGS Administrators (L38955)
Enteral nutrition – standardized formula			✓	Preview questionnaire	Enteral Nutrition CGS Administrators (L38955)
Gastric pacing / stimulation	✓	✓	✓	Preview questionnaire	Gastric Electrical Stimulation medical policy
Hammertoe correction surgery	✓	✓	✓	Preview questionnaire	InterQual Procedures Adult Criteria, Arthrodesis or Arthroplasty, Interphalangeal Joint, Second-Fifth Toes
Not otherwise classified codes		✓	✓	Preview questionnaire	Applicable Medicare guidelines or medical policies
Oral surgery		✓		Preview questionnaire	Oral Surgery medical policy
Orthognathic surgery		✓		Preview questionnaire	Orthognathic Surgery medical policy
Panniculectomy (previously known as abdominoplasty)		✓		Preview questionnaire	Panniculectomy medical policy
			✓	Preview questionnaire	Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051)
Prostatic urethral lift		✓	✓	Preview questionnaire	Prostatic Urethral Lift Procedure for the Treatment of BPH medical policy

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Rhinoplasty		✓		Preview questionnaire	Cosmetic and Reconstructive Surgery medical policy
	✓		✓	Preview questionnaire	Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051)
Sacral nerve neuromodulation / stimulation for fecal incontinence		✓		Preview questionnaire	<ul style="list-style-type: none"> Sacral Nerve Neuromodulation/Stimulation medical policy National Coverage Determination for Sacral Nerve Stimulation for Urinary Incontinence (230.18)
Sacral nerve neuromodulation / stimulation for urinary incontinence		✓		Preview questionnaire	<ul style="list-style-type: none"> Sacral Nerve Neuromodulation/Stimulation medical policy
			✓	Preview questionnaire	<ul style="list-style-type: none"> National Coverage Determination for Sacral Nerve Stimulation for Urinary Incontinence (230.18)
Septoplasty	✓	✓	✓	Preview questionnaire	<ul style="list-style-type: none"> InterQual Procedures Adult Criteria, Septoplasty Local Coverage Determination for Cosmetic and Reconstructive Surgery (L39051)
Temporomandibular joint surgery		✓		Preview questionnaire	Temporomandibular Joint Disorder medical policy

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Varicose vein treatment		✓		None — answer a series of questions in the e-referral system	Treatment of Varicose Veins/Venous Insufficiency medical policy
	✓		✓		Local Coverage Determination for Treatment of Varicose Veins of the Lower Extremities (L34536)
Visual training, orthoptic and pleoptic		✓	✓	Preview questionnaire	<ul style="list-style-type: none"> • Orthoptic Training/Vision Therapy for the Treatment of Vision or Learning Disabilities medical policy • Member certificate or benefit document