INTERQUAL CRITERIA

The InterQual Criteria provide support for determining the appropriateness of admission, continued stay and discharge for patients with multiple conditions or comorbidities. The Acute criteria address the observation, critical, high dependency, and acute levels of care and an additional 4 levels of Newborn care in pediatrics that include: Neonatal Intensive Care Level III, Newborn Level II, Newborn Level I, and Newborn Transitional Care.

Supporting reference materials are provided with the criteria and should be used to assist in correct interpretation of the criteria. They can be found in CareEnhance Review Manager Clinical Reference Help.

REFERENCE MATERIALS

- Alternate Level of Care (ALOC) Guidelines: helps identify appropriate level of care options.
- Glossary: contains general notes that provide definitions, detail related to specific criteria points and care management notes.
- Abbreviations and Symbols List: defines acronyms, abbreviations, and symbols used in the criteria.
- Inpatient List: identifies procedures that are appropriate for the inpatient setting.
- Bibliography: lists clinical evidence classification and supporting references.
- Index: lists diagnoses and symptoms with associated criteria subsets to help identify the appropriate criteria subset.
- Quality Indicators: contains National Quality Forum’s standard set of hospital quality measures.

AGE PARAMETERS

Adult criteria are for review of patients ≥ 18 years of age. Pediatric criteria are for review of patients < 18 years of age.

LEVEL OF CARE REVIEW TYPES

There are five types of reviews that can be performed using the InterQual Level of Care Criteria.

- Preadmission Review – Performed only for a planned admission for a procedure to determine the appropriateness of an admission prior to the procedure being performed. Reviews are completed using the Severity of Illness (SI) Criteria only.
- Admission Review – Performed to determine appropriateness of admission to a level of care. Reviews are completed for an admission and when a patient is transferred to a higher level of care. Reviews are completed using the Severity of Illness (SI) and Intensity of Service (IS) Criteria.
- Continued Stay Review – Performed to determine if the level of care is still appropriate. Reviews are completed using the Intensity of Service (IS) Criteria.
- Discharge Review – Performed to determine the safety of discharge or transfer from one level of care to another. Reviews are completed using the Discharge Screen (DS) criteria.
- Secondary or Secondary Medical Review – A next level review performed when the primary review does not meet criteria and a second opinion is required. The organisation determines the qualifications of the secondary reviewers. Medical review is required for an outcome that is not approved.
PREADMISSION REVIEW

Preadmission Review

A preadmission review may be completed when a patient is being admitted to the hospital prior to an elective surgery or procedure. Criteria are found in the following subsets.

<table>
<thead>
<tr>
<th>Preadmission review for:</th>
<th>Apply the Severity of Illness Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective surgery or procedure, use the Acute Surgery/Trauma subset.</td>
<td>Elective surgery / invasive procedure, ≥ one:</td>
</tr>
<tr>
<td></td>
<td>➢ Designated inpatient setting and performed same day as admission</td>
</tr>
<tr>
<td></td>
<td>➢ High risk for thromboembolism</td>
</tr>
<tr>
<td>Pre-op transplant or donor, use the Transplant subset.</td>
<td>Elective transplant / living donor procedure and performed w/in 24h of admission</td>
</tr>
<tr>
<td>C-section or induction, use the OB/GYN/GU subset.</td>
<td>C-section / Induction and scheduled same day as admission, ≥ one:</td>
</tr>
<tr>
<td></td>
<td>➢ At term / Post term</td>
</tr>
<tr>
<td></td>
<td>➢ Foetal demise</td>
</tr>
</tbody>
</table>

Preadmission Review Steps

1. Select the appropriate subset and apply the Severity of Illness (SI) criteria.
2. Confirm that either:
   • The admission date is the same as the scheduled procedure date and the procedure appears on an approved inpatient list or the patient is high risk for thromboembolism.
   • The admission is for an elective transplant or living donor procedure and performed within twenty-four hours of admission.
   • The admission date is the same as the C-section or Induction date.
3. Continue according to the following recommended actions.

Preadmission Review Actions

<table>
<thead>
<tr>
<th>For these review findings</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission rule met</td>
<td>• Approve planned admission.</td>
</tr>
<tr>
<td>Preadmission rule not met</td>
<td>• Contact the medical practitioner for additional information to verify the need for admission to the inpatient setting.</td>
</tr>
<tr>
<td></td>
<td>• If the additional information satisfies the preadmission rule, the planned admission may be approved.</td>
</tr>
<tr>
<td></td>
<td>• If the additional information does not satisfy the preadmission rule, refer for Secondary Review. (See &quot;Secondary Review Process&quot;)</td>
</tr>
</tbody>
</table>

ADMISSION REVIEW

Admission Review

An admission review is performed when the patient is admitted to a level of care to determine if that level of care is appropriate. If the patient is transferred from a lower level of care to a higher level care, an admission review is also required. Both the Severity of Illness (SI) criteria and the Intensity of Services (IS) criteria rules from the same criteria subset must be met on admission.
**Review Type** | **Review Rule**
--- | ---
Admission review | Apply the Severity of Illness (SI) and Intensity of Service (IS or *IS) criteria.

**Admission Review Steps**

1. Identify the level of care based on the patient’s current or proposed level.
2. Select the most appropriate criteria subset based on the patient’s predominant presenting clinical findings. For example, a patient is admitted with vomiting that was unresponsive to antiemetics; you would use the Gastrointestinal / Biliary / Pancreatic subset.
3. Obtain and review patient specific clinical information derived at the time of admission. Emergency room data such as imaging studies, EEG findings, history and physical, and medical practitioner instructions can be used to complete the admission review.
   **NOTE:** Once the decision is made to admit the patient, the SI and IS rules should be reviewed. Although SI and IS must be met within the designated time, in reality, a review is often performed within hours of, or a day after, a patient’s admission.
4. Apply the SI rule by selecting the SI criteria based on the patient’s clinical findings, making sure to meet all the rules for time of onset and number of criteria.
5. Apply IS by selecting the IS criteria based on prescribed treatments, medications, or interventions from the same criteria subset used to select SI, making sure to meet all the rules for duration and number of criteria.
   **Note:** Some SI criteria points have a corresponding IS. For an admission review, if the chosen SI criterion has a corresponding IS criterion, the reviewer should select this specific criterion point. For example, when a patient presents on admission with CHF and the reviewer determines the criteria “CHF and haemodynamic stability requiring IV medication titration” in the High Dependency Cardiac subset is appropriate, the reviewer would then select the corresponding IS for the condition “CHF, BOTH”.
6. Continue according to the following recommended actions.

**Admission Review Actions**

<table>
<thead>
<tr>
<th>For these Review findings</th>
<th>Do this</th>
</tr>
</thead>
</table>
| SI and IS rule *met*      | • Approve admission to level of care.  
                            | • Schedule Continued Stay review. |
| SI or IS rule *not met*   | • Obtain additional information from the medical practitioner or other caregivers.  
                            | • If additional information does not meet the corresponding SI or IS/*IS, discuss alternate levels of care with medical practitioner.  
                            | • Facilitate transfer if the medical practitioner is agreeable to an alternate level of care.  
                            | • Refer for Secondary Review if the medical practitioner does not agree with alternate level of care. (See “Secondary Review Process”)|

**CONTINUED STAY REVIEW**

**Continued Stay Review**

A continued stay review is performed to determine the appropriateness of continued stay at a level of care.
### Continued Stay Review Steps

1. Begin at the same criteria subset used during the admission review, unless:
   - The patient has been transferred to a lower level of care. In this case, select the appropriate criteria subset, based on the patient’s clinical information.
   - The patient has been transferred to a higher level of care, then conduct an admission review.
   - The patient remains at the current level of care, but the medical condition has changed, then the reviewer may use a different subset within that level of care and would only need to apply IS criteria.

2. Obtain and review patient specific clinical information (e.g., progress notes, medical practitioner instructions, medication, and treatment records).

3. Apply IS by selecting the IS criteria based on prescribed treatments, medications, or interventions making sure to meet all the rules for duration, time frames and number of criteria.

4. Continue according to the following recommended actions.

### Continued Stay Review Actions

<table>
<thead>
<tr>
<th>For these Continued Stay review findings</th>
<th>Do this</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS met</td>
<td>Approve level of care for that day. Schedule Continued Stay review.</td>
</tr>
<tr>
<td>Three *IS met</td>
<td>Approve level of care for that day. Review the discharge screens and document the discharge plan. Schedule a Continued Stay review.</td>
</tr>
<tr>
<td>IS or three *IS not met or IS and discharge review criteria are selected</td>
<td>Obtain additional information from the medical practitioner or other caregivers. If IS or three *IS still not met, perform discharge review (See &quot;Discharge Review&quot;).</td>
</tr>
</tbody>
</table>

### DISCHARGE REVIEW

#### Discharge Review

Discharge reviews are performed when criteria for continued stay are not met, an IS criterion is selected that states "and discharge review", or to assist in determining the next appropriate level of care within the facility (a transfer to another unit) or discharge from the facility.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>Apply Discharge Screen (DS) criteria for the next appropriate level of care.</td>
</tr>
</tbody>
</table>

#### Discharge Review Steps

1. Select the same criteria subset used for the admission or continued stay review and apply the DS rule for the appropriate level of care.
2. Continue according to the following recommended actions.
### Discharge Review Actions

<table>
<thead>
<tr>
<th>For this review reason</th>
<th>With these findings</th>
<th>Do this</th>
</tr>
</thead>
</table>
| IS or three *IS not met or IS and discharge review selected | DS met | • If discharge is scheduled, no action required.  
• If discharge is not scheduled:  
• Contact the medical practitioner to discuss the discharge plan and alternate level of care options.  
• Facilitate discharge or transfer if the medical practitioner agrees.  
• Refer for Secondary Review if the medical practitioner does not agree with the alternate level of care. (See "Secondary Review Process") |
| DS not met | • Approve the day and schedule the next review within 24 hours.  
• On next review, if DS still not met, refer for Secondary Review. (See "Secondary Review Process") |

### DOCUMENTING VARIANCES

When Discharge Screens are met and an alternate level of care is appropriate, but unavailable, the reviewer should:

1. Indicate the reason the patient has not been transferred.
2. Assign a level of care that represents the alternate level of care, which would be appropriate for the patient had it been available.
3. Document the number of days (referred to as variance days) used at a specific level of care when a less intensive, less costly level is appropriate.
4. Discuss the case with a secondary reviewer and document the review decision.

### SECONDARY REVIEW

A supervisor, specialist (e.g., therapist, wound ostomy nurse) or medical practitioner may conduct a secondary review. Organisational policy should determine the qualifications of the reviewers as well as the extent to which secondary review(s) is performed in order to render a review outcome. The secondary reviewer determines the medical necessity of admission or continued stay based on review of the medical record, discussions with nursing, discharge planner, and attending medical practitioner, and by applying clinical knowledge.

#### When is a Secondary Review Appropriate?

- Review rules are not met.
- You have questions about the quality of care.

#### What Questions Does a Secondary Review Address?

- Does the patient require this level of care?
- What are the treatment options?
- Is there a quality of care question?
- Should a specialist evaluate this case?

#### Secondary Review Process

The Secondary Review process determines the appropriateness of the current or alternate level of care. Follow these steps when you conduct a Secondary Review:
If the secondary reviewer agrees with the existing level of care, approve the level of care and schedule the next review.

If the secondary reviewer does not agree with the existing level of care, he or she discusses the alternate level of care options for this patient with the medical practitioner.

- If the medical practitioner agrees with the secondary reviewer, facilitate the transfer to the alternate level of care, if available.
- If the medical practitioner does not agree with the secondary reviewer, initiate action as approved by organisational policy.

If the alternate level of care is unavailable, finalise the Variance Code.

Document the review outcome.

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 healthcare 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 LEVEL OF CARE COMPONENTS

**Severity of Illness (SI)** criteria consist of objective, clinical indicators of illness, which focus on an individual patient’s clinical presentation and/or diagnosis.

- The SI rule requires One SI criteria to be met.
- The time requirements vary based on the level of care.
  - Onset within 24h (e.g., Observation)
  - Onset within 1 wk (e.g., Acute Care)
- SI criteria are grouped by reason for admission and alphabetised for ease of use and quick reference.
- Most criteria subsets are organised into the following categories:
  - CLINICAL FINDINGS
  - IMAGING FINDINGS
  - ECG FINDINGS
  - LABORATORY FINDINGS
- Observation, Infectious Disease, and Obstetrics/Gynaecology/Genitourinary criteria subsets are organised by body system.
- OB-Antepartum criteria subset is organised by HIGH RISK OBSTETRICS, LABORATORY FINDINGS and MEDICAL COMORBID CONDITIONS.

**Intensity of Service (IS)** criteria consists of monitoring and therapeutic services, singularly or in combination, that can only be administered at a specific level of care.

- The IS rule requires that One IS or Three *IS criteria be met.
- Care facilitation IS criteria are included in the Acute Level of Care. These criteria suggest alternate levels of care that may be appropriate for patients who are approaching discharge readiness. These IS criteria are denoted by a Ø symbol and have “Discharge review” or “and discharge review” with suggested levels of care attached to the criterion. For example:
  - Chest tube, one:
    - Suction, continuous
    - Ø ≤ 200mL/d and discharge review (HC / SAC)
  - The time requirement requires that IS must be “At Least Daily”.

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Some IS criteria specify other time designations. For example, the criterion "Corticosteroids ≥ 3x/24h" specifies that corticosteroids should be administered at least three times within a 24-hour period and overrides the "At Least Daily" designation.

Some IS are associated with a duration of time, which are intended to allow the reviewer to approve up to the number of days indicated. The days are based on a calendar day, which start at 12:01 a.m. regardless of the time of admission. However, the exception to this would be admissions in the evening (e.g., after 6 p.m.); in which case, day one would not begin until the next day.

NOTE: Regulatory or contractual agreements may dictate other specifics concerning when the "new day" begins.

*IS criteria have been standardised within each level of care (i.e., Critical Care, High Dependency Care, and Acute Care) for ease of use and to cover treatments and medications specific to common complications and comorbid conditions.

*IS are important case management flags that prompt the reviewer to perform a discharge review. Patients who meet three *IS are approaching discharge readiness and will most likely transition quickly from the current level to an alternate level of care.

**Discharge Screens (DS)**

The Discharge Screens are organised by levels of care and provide objective clinical indicators to determine if the patient has reached the level of clinical stability appropriate for safe transfer to that level of care. The DS criteria assist the reviewer in determining whether an alternate level of care is appropriate based on ongoing service needs.

The DS rule requires One: ALOC to be met.

The time requirement for adult criteria is "At Least Last 12h" and for the paediatric criteria it is "At Least Last 24h".

Some DS criteria specify a different time designation, as some criteria require more or less time to ensure safe discharge or transfer. The time associated with a specific DS criterion overrides the general time requirement. For example:
- In adult, "Pre-op transplant stabilised last 24h" (Adult Critical Care Surgical Trauma) overrides the "At Least Last 12h".
- In paediatric, "Airway / Tracheostomy stable last 7d ..." (Paediatric Intensive Care) overrides the "At Least Last 24h".

The Acute level DS are organised by the least to most intensive alternate levels of care, while the Critical, High Dependency, and Newborn levels, are organised by most intensive to least intensive alternate levels of care.

**TRANSITION PLAN**

This guideline is intended to serve as a tool to assist the reviewer in planning for a safe transition to the most appropriate post-acute level of care. Reviewers are encouraged to begin using the Transition Plan tool at the time of admission. The Transition Plan:

- Is NOT a required part of the Review Process
- Outlines interventions necessary to ensure continuity of quality care
- Identifies patients who are at high risk of readmission
- Provides a framework for identifying discharge needs

**Practical Tips**

**Process**

- Review all notes attached to criteria subsets, rules, and criterion points.
• The reviewer may select as many criteria as the rule(s) allow, or as specified by
organisational policy for documentation purposes, as long as the minimum number of
criteria have been met. For example, when the rule displays as "≥ One:," the reviewer
can select one or more than one underlying criteria point(s). When the rule displays as
"One:," the reviewer should select only one criterion.

• PRN medication can be used to meet the IS criteria during an Admission Review when
actual administration can be determined and the required frequency (e.g., 3x/24h) is
met.

• Oxygen saturation (O₂ sat) measurements are based on room air readings, unless the
criterion states otherwise.

• When a patient is transferred to a new facility, for a service that is unavailable at the
current facility, to be closer to family, or at the request of the payer, an admission review
is not necessary if criteria were met at the transferring facility. An admission review
would be required for an increase in level of care (e.g., from acute to high dependency
care).

• When a slash ( / ) occurs in the criteria, it represents the term "or." For example, in
the criterion for "CNS infection / Meningitis ≤ 3d," this should be interpreted as "CNS
infection ≤ 3d" or "Meningitis ≤ 3d". When criteria points are more complex, the case
type (e.g., capital or lower case letters) assists the reviewer in interpreting the
criteria. For example:
  ➢ "Hyperbaric oxygen and gangrene / osteomyelitis / necrotizing soft tissue
    infection." Because the first letters after the slash are in lower case, the correct
    interpretation of this criterion is "Hyperbaric oxygen and gangrene," or "Hyperbaric
    oxygen and osteomyelitis," or "Hyperbaric oxygen and necrotizing soft tissue
    infection."
  ➢ "Fracture / Dislocation, cervical / thoracic / lumbar vertebrae" should be
    interpreted as "Fracture, cervical vertebrae," or "Fracture, thoracic vertebrae," or
    "Dislocation, cervical vertebrae," or "Dislocation, thoracic vertebrae," or "Dislocation,
    lumbar vertebrae."
  ➢ "Disorientation / Agitation / Increasing irritability / lethargy" should be interpreted
    as "Disorientation," or "Agitation," or "Increasing irritability," or "Increasing lethargy."

• Emergency Department data can be used to meet the SI and IS. For example:
  ➢ A patient presents to the emergency department with an O₂ sat level of 88% (0.88).
    Oxygen therapy is initiated at 40% (0.40) and the patient is scheduled for
    admission. On admission, the patient has an O₂ sat of 91% (0.91) and 40% (0.40)
    oxygen is ordered to be continued. Selection of SI and IS would be appropriate
    based on the O₂ sat level documented in the emergency department and the
    ongoing need for oxygen supplementation.
  ➢ Medical practitioner instructions that were initiated in the emergency department or
during Observation Status that are instructed to be continued after admission may
be used to meet the IS criteria.

  NOTE: Treatments or services that are only given once while in the ED cannot be
used to meet IS for admission. General exceptions to this include: cardioversion,
thrombolitics and emergency pericardiocentesis

• Ø IS selected on admission review will not meet criteria. The reviewer should use the
Discharge Screens to determine an alternate level of care that can provide the necessary
services to meet the patient's clinical needs.

• When there are a range of days (e.g., ≤ 2d) associated with an IS criterion, the reviewer
may approve up to the time frame, eliminating the need for daily review. The Discharge
Screens may be used to validate that the patient is not clinically stable for transfer or
discharge before the end of the time frame.

• When criteria states "within normal limits (WNL)" or "within acceptable range", it may be
considered WNL when a patient returns to their personal baseline.

• Patients who meet three *IS are approaching discharge readiness. *IS are important case
management flags to prompt the reviewer to review the DS screens to assist in
determining the next appropriate level of care.
If allowed by your organisation's policy, a 24-hour grace period can be given, one time only, when DS are not met and the IS rule (One IS / Three *IS) is not met.

Examples:
- A therapeutic pause is needed. This could be due to planned intermittent therapy or side effects that need to clear before initiating a new regimen.
  - High-dose steroids in a cardiovascular patient are scheduled for two days on and one day off.
  - A renal patient's IV therapy has been discontinued due to adverse effects and time is needed to allow the medication to clear the patient's system before instituting a new medication.
- A patient is meeting only two *IS but does not meet DS and it is anticipated that they will be ready for discharge within 24 hours.

Level of Care
- When a hospital unit's name (e.g., Progressive Care Unit) does not match the InterQual Criteria subset titles, refer to the Subset Level note located on the title page of a specific criteria subset. The minimum requirements for monitoring and interventions generally provided at the specific level of care will be noted.
- A higher level of care criteria may be used when the setting has the capability to provide the higher level services. For example, an acute care unit has the capability to provide High Dependency level of care, e.g., telemetry. High Dependency Care criteria can be used to approve admission to acute care.
- A lower level of care criteria may be used to review at a higher level of care, when the facility does not have the lower level of care. For example, the facility does not have an High Dependency care unit, and cardiac monitoring cannot be provided on an acute care unit, the High Dependency Criteria may be used to approve an admission or continued stay in a Critical Care Unit. Note: This is an exception to the general rule that lower level of care criteria cannot be used to approve an admission or continued stay to a higher level of care.
- When a patient is located at a level of care that is different from the assigned level of care, the reviewer should use the Criteria set aligned with the level of care assignment. For example, the patient is in an acute care bed, but is assigned observation status; the Observation Criteria are used for review.
- An infant who is \( \leq 31 \) days old is admitted to an acute care facility, the reviewer should use the appropriate Newborn Level subset that corresponds to the severity and intensity of services the infant is receiving, regardless of location.