INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

INTERQUAL CRITERIA

The InterQual Criteria provide support for determining the appropriateness of admission, continued stay and discharge destination. The Acute Rehabilitation level of care criteria address both the adult and pediatric population and include an adult subset for the Subacute rehabilitation level of 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 and in book format. Additionally, the MHS Customer Hub (http://mhscustomerhub.mckesson.com) provides interactive support, answers to commonly asked questions, and links to other resources, (e.g., Drug list, Bibliography).

REFERENCE MATERIALS

- Alternate Level of Care (ALOC) Guidelines: helps identify appropriate level of care options.
- Length of Stay: provides length of stay reference data based on diagnosis.
- 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.
- Index: lists diagnoses and symptoms with associated criteria subsets to help identify the appropriate criteria subset.

AGE PARAMETERS

The InterQual Adult Rehabilitation criteria and Subacute Criteria are for the review of patients ≥ 18 years of age. The Pediatric Acute Rehabilitation Criteria are for 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 to a level of care to determine the appropriateness of an admission. 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 Criteria.
- Discharge Review – Performed to determine the safety of discharge or transfer from one level of care to another. Reviews are performed using the Discharge Screen (DS) criteria.
- Secondary or Secondary Medical Review – A next level review performed when the primary review does not meet criteria. The organization determines the qualifications of the secondary reviewers. Medical review is required for an outcome that is not approved.
INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

PREADMISSION REVIEW

Preadmission Review
A preadmission review is conducted prior to admission and Severity of Illness criteria are applied.

<table>
<thead>
<tr>
<th>Preadmission review for:</th>
<th>Apply the Severity of Illness (SI) criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned admission or transfer</td>
<td>Before admission.</td>
</tr>
</tbody>
</table>

Preadmission Review Steps
1. Identify the level of care based on the patient’s current or proposed level.
2. Select the appropriate subset based on the patient’s predominant presenting rehabilitation needs.
3. Obtain and review patient specific clinical information (e.g., history, physical, laboratory, imaging, progress notes, and medical practitioner orders).
4. Apply the SI rule by selecting the SI criteria based on the patient’s clinical findings and rehabilitation needs, making sure to meet all the rules for time of onset and number of criteria.
5. 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>
</tbody>
</table>
| Preadmission rule not met | • Contact the attending medical practitioner for additional information to verify the need for admission to the Acute or Subacute Rehabilitation level of care.  
• If the additional information satisfies the preadmission rule, the planned admission may be approved.  
• If the additional information does not satisfy the preadmission rule, refer for Secondary Review. (See "Secondary Review process") |

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. 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.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Review</td>
<td>Apply the Severity of Illness (SI) and Intensity of Service (IS) criteria derived from the first 48 hours of admission.</td>
</tr>
</tbody>
</table>
INTERRQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

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 rehabilitation needs and clinical presentation.
3. Obtain and review patient specific clinical information (e.g., history, physical, laboratory, imaging, progress notes, and medical practitioner orders).
4. Apply the SI rule by selecting the SI criteria based on the patient’s clinical findings and rehabilitation needs, 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 therapy, treatments, or interventions from the same criteria subset used to select SI, making sure to meet all the rules for duration and number of criteria.
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>
<tbody>
<tr>
<td>SI and IS rule met</td>
<td>• Approve admission to level of care.</td>
</tr>
<tr>
<td></td>
<td>• Schedule Continued Stay review.</td>
</tr>
<tr>
<td>SI or IS rule not met</td>
<td>• Obtain additional information from the attending medical practitioner or other caregivers.</td>
</tr>
<tr>
<td></td>
<td>• If additional information does not meet the corresponding SI or IS, discuss alternate levels of care with the attending medical practitioner.</td>
</tr>
<tr>
<td></td>
<td>• Facilitate transfer if the attending medical practitioner agrees with an alternate level of care.</td>
</tr>
<tr>
<td></td>
<td>• Refer for Secondary Review if the attending medical practitioner does not agree with alternate level of care. (See “Secondary Review process”)</td>
</tr>
</tbody>
</table>

CONTINUED STAY REVIEW

Continued Stay Review

A continued stay review is performed to determine the appropriateness of continued stay at a level of care.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Stay</td>
<td>Apply the Intensity of Service criteria (IS).</td>
</tr>
<tr>
<td><strong>IMPORTANT:</strong></td>
<td>Continued Stay Review should be performed at least weekly, however, this may vary based on organizational policy. On each review, the reviewer should evaluate the case since the last review to ensure the Intensity of Service (IS) has been met daily.</td>
</tr>
</tbody>
</table>
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REVIEW PROCESS

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 is transferred to a higher level of care, then conduct an admission review, applying both SI and IS to determine if admission to the higher level is clinically appropriate.
   - 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., medical practitioner, nursing, therapy, and interdisciplinary team progress notes, medical practitioner orders, medication and treatment records).

3. Apply IS by selecting one responder type based on the prescribed therapy, treatments or interventions, making sure to meet all the rules for duration, time frames and number of criteria. Responder types include:
   - Partial Responder: Criteria that indicate the patient is appropriate for continued stay.
   - Responder: Criteria that indicate the patient is appropriate for discharge or transfer. Selection of these criteria “do not meet” for continued stay and are denoted by the $\exists$ symbol.

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>
</table>
| IS Partial Responder **met** | • Approve level of care.  
• Schedule Continued Stay review. |
| IS Responder **met** | • Prepare for discharge or transfer. Review discharge screens to determine the most appropriate post acute level of care. |
| IS Partial Responder and Responder **not met** | • Obtain additional information from the attending medical practitioner or other caregivers.  
• If IS still not met, perform discharge review. (See “Discharge Review”). |
Discharge Review

Discharge reviews are performed when criteria for continued stay are not met as determined by selection of the Responder criteria or when Partial responder criteria are not met. A Discharge review can 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>

**IMPORTANT:** The word “Discharge” in Discharge Screens refers to discharge (transfer) from one level to another level of care, not necessarily discharge from the facility.

Discharge Review Steps

1. Select the same criteria subset used for 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 Partial Responder not met or IS Responder and Partial Responder not met | DS met | • If discharge is scheduled, no action required.  
• If discharge is not scheduled:  
  - Contact the attending medical practitioner to discuss the discharge plan and alternate level of care options.  
  - Facilitate discharge or transfer if the attending medical practitioner agrees.  
  - Refer for Secondary Review if the attending medical practitioner does not agree with the alternate level of care. (See “Secondary Review Process”) |
| | DS not met | • Refer for Secondary Review if the attending medical practitioner does not agree with the alternate level of care. (See “Secondary Review Process”) |

**DOCUMENTING VARIANCES**

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

- Indicate the reason the patient has not been transferred.
- Assign a level of care that represents the alternate level of care, which would be appropriate for the patient had it been available.
- 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.
- 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. Organizational 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 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 attending medical practitioner.
  - If the attending medical practitioner agrees with the secondary reviewer, facilitate the transfer to the alternate level of care, if available.
  - If the attending medical practitioner does not agree with the secondary reviewer, initiate action as approved by organizational policy.
- If the alternate level of care is unavailable, finalize 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

The InterQual Rehabilitation Criteria cover adult and pediatric populations. The Adult Criteria are organized into Acute and Subacute subsets. The Pediatric subset covers Acute Rehabilitation.

Severity of Illness (SI) criteria consist of objective clinical indicators.
- The SI rule requires All SI criteria be met.
- The time requirements vary based on the level of care. If there is a time requirement, it is associated with an SI criterion.
  Example:
  Illness / Injury / Surgery ≤ 30d
  (Adult and Pediatric Rehabilitation)
- SI criteria address:
  - The clinical features of the patient’s illness appropriate for the specific level of rehabilitation care.
INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

- Patient’s ability and willingness to benefit from a comprehensive acute or subacute rehabilitation program.
- The unavailability of services at a lower level of care.

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

- The IS rule requires that Partial responder criteria be met.
- Partial Responder: Criteria that indicate the patient is appropriate for continued stay,
- Responder: Criteria that indicate the patient is appropriate for discharge. Selection of these criteria "do not meet" for continued stay and are denoted by the $\lessdot$ symbol.
- The IS time requirement is "At Least Daily."
- IS criteria include requirements for duration of therapy per day and the number of days per week.

Examples:
- At least 2 disciplines $\geq 3h/d \geq 5d/wk$ (Adult and Pediatric Rehabilitation)
- At least 2 disciplines $\geq 2-3h/d \geq 5d/wk$ (Subacute Rehabilitation)

- Some IS criteria 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 starts 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.

Example:
"Medical instability (new onset) decreases participation in therapy $< 3h/d$ for $\leq 3d$...”. If the patient was able to participate in therapy on a given day and developed a new medical instability later that evening, then the first day of counting the decrease in therapy would start the next morning.

Discharge Screens (DS) consist of level of care appropriateness and clinical stability criteria. They are organized by alternate levels of care.

- The DS rule requires One: ALOC
- The Rehabilitation level DS are organized by the least to most intensive alternate levels of care. For additional levels of care not identified, a list of appropriate alternate levels of care can be found in the Appendix or in CareEnhance® Review Manager Help.

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
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REVIEW PROCESS

Practical Tips

Process

- Review all notes attached to criteria subsets, rules, and criterion points.
- When the criteria indicates “within normal limits (WNL),” “within acceptable range,” or “at baseline”, it refers to when a patient returns to his or her personal baseline.
- The reviewer may select as many criteria as the rule(s) allow, or as specified by organizational policy for documentation purposes, as long as the minimum number of criteria has 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.
- When a slash (/) occurs in the criteria, it represents the term “or.” For example, “Mobility / Motor impairment,” should be interpreted as “Mobility impairment” or “Motor impairment”.
- 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:
  - “Able to follow visual / verbal commands / Follows one-step commands.” Because the first letters after the slash are in lower case, the correct interpretation of this criterion is “Able to follow visual commands,” or “Able to follow verbal commands” or ”Follows one-step commands”.
  - “Full participation in / Responsive to therapeutic evaluation and interventions prior to transfer” should be interpreted as “Full participation in therapeutic evaluation and interventions prior to transfer” or “Responsive to therapeutic evaluation and interventions prior to transfer”.
- 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 weekly or 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.

Level of Care

- When a facility’s name (e.g., Transitional Care Unit) does not match the InterQual Criteria subset titles, refer to the Subset Level note located on the title page of a specific subset. The minimum requirements for monitoring and interventions generally provided at the specific level of care will be noted.
- 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 rehab bed, but is assigned subacute rehab; the Subacute rehab criteria are used for review.