INTERQUAL® SUBACUTE & SNF CRITERIA
REVIEW PROCESS
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INTERQUAL CRITERIA

The InterQual Criteria provide support for determining the appropriateness of admission, continued stay and discharge appropriate discharge destinations. The Subacute & SNF level of care criteria address the needs of both adults and pediatrics.

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.
- **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

InterQual Subacute & SNF Criteria, Level I, II and III are for the review of patients ≥ 18 years of age. The Pediatric Medical subset 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 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 (IS) of Service 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.
- **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.
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. Determine if the primary reason for admission is for medical treatment, or rehabilitation, or both and then select the appropriate subset based on the patient’s predominant presenting clinical and/or therapy findings.
3. Obtain and review patient specific clinical information: (e.g., history, physical, laboratory, imaging, ECG finding, progress notes, and medical practitioner orders).
4. Apply the SI rule by selecting the SI criteria based on the patient’s clinical findings and/or therapy 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 Subacute/SNF 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>
INTERQUAL® SUBACUTE & SNF CRITERIA
REVIEW PROCESS

Admission Review Steps

1. Identify the level of care based on the patient’s current or proposed level.
2. Determine if the primary reason for admission is for medical treatment or rehabilitation, or both and then select the appropriate subset based on the patient’s predominant presenting clinical and/or therapy findings.

   NOTE: For adult patients presenting with both medical and therapy needs, the appropriate subset is Level III, Complex Care.

3. Obtain and review patient specific clinical information: (e.g., history, physical, laboratory, imaging, ECG finding, progress notes, and medical practitioner orders).
4. Apply the SI rule by selecting the SI criteria based on the patient’s clinical findings and/or therapy 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 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.
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 the level of care.</td>
</tr>
<tr>
<td></td>
<td>• Schedule Continued Stay review.</td>
</tr>
</tbody>
</table>

| SI or IS rule not met     | • Obtain additional information from the attending medical practitioner or other caregivers. |
|                          | • If additional information does not meet the corresponding SI or IS, discuss alternate levels of care with the attending medical practitioner. |
|                          | • Facilitate transfer if the attending medical practitioner agrees with an alternate level of care. |
|                          | • Refer for Secondary Review if the attending 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.

<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>
</tbody>
</table>

IMPORTANT: 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.
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 (e.g., transfer from Level III to Level I Skilled care). In this case, select the appropriate criteria subset based on the patient's clinical information and apply IS criteria.
   - The patient is transferred to a higher level of care (e.g., Level I Skilled care to Level II or III Subacute care), then conduct an admission review, applying both SI and IS to determine if admission to the higher level is clinically appropriate.
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 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.</td>
</tr>
<tr>
<td></td>
<td>• Schedule Continued Stay review.</td>
</tr>
<tr>
<td>IS not met</td>
<td>• Obtain additional information from the attending medical practitioner or other caregivers.</td>
</tr>
<tr>
<td>IS and discharge review selected</td>
<td>• If 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>

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 not met or IS and discharge review selected | 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 | |
| |

**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. 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:

1. If the secondary reviewer agrees with the existing level of care, approve the level of care and schedule the next review.
2. 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.
3. If the alternate level of care is unavailable, finalize the Variance Code.
4. 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 Subacute & SNF Criteria are organized into three adult subsets and one pediatric subacute subset. The Adult subsets include Level I: Skilled care, Level II: Subacute care, and Level III: Complex care. Level I and II criteria are for patients requiring medical or therapy services. Level III Complex Care criteria are for patients requiring both medical and therapy services.

Severity of Illness (SI) criteria consists of objective clinical indicators.
- The SI rule requires All SI criteria be met.
- The time requirement is ≤ 30d for all criteria subsets.
- The clinical indicators for all subsets include the patient’s illness, clinical stability criteria, and why services are precluded 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 is:
  - Adult:
    - Level I and Level II: ≥ One Medical or ≥ One Therapy
    - Level III: Both: Medical and Therapy
  - Pedi:
    - ≥ One Medical or ≥ One Therapy
- The IS time requirement is "At Least Daily."
• **Care facilitation** IS 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.

  **Example:**
  
  **Discharge review, one:**
  - Functional plateau reached / Minimal functional gains ≥ 1wk, ≥ one:
  - Ø Prior level of function achieved (Home / OP)
  - Ø Rehabilitation goals met (Home / OP)

• Some IS criteria are associated with a duration of time, which 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.

  **Example:**
  "IV fluids ≥ 75 mL/h ≤ 3d" If the patient was admitted late in the evening and was started on IV fluids, then the next morning would be the day one.

  **NOTE:** Regulatory or contractual agreements may dictate when the "new day" begins.

**Discharge Screens (DS)** consist of level of care appropriateness, clinical stability, and care coordination criteria. They are organized by alternate levels of care as suggested by the care facilitation IS.

- The DS rule requires One: ALOC.
- Some DS criteria specify a time designation to ensure safe discharge / transfer, for example, "Hemodynamic and neurologic stability ≥ 24h."
- The DS criteria 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

**Practical Tips**

**Process**

- Review all notes attached to criteria subsets, rules, and criterion points.
- The adult Level I and Level II subsets are applied when the patient has a medical or therapy need. If the patient experiences a medical instability and cannot participate in ongoing therapy, the reviewer can use the medical criteria from the same subset to validate the continued stay.
• The adult Level III (Complex care) subset is designed for use when the patient has both medical and therapy needs. If the patient experiences a medical instability and cannot participate in ongoing therapy, the Level II or Level I subset can be used to validate the continued stay by applying IS criteria only.

• 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 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.

• When a slash (/) occurs in the criteria, it represents the term "or." For example, in the criterion for "Chemotherapy / Malignancy complication expected to resolve in ≥ 3d,” this should be interpreted as “Chemotherapy complication expected to resolve in ≥ 3d “ or "Malignancy complication expected to resolve in ≥ 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:
  ➢ "Loss / Damage of skin ≥ 15% (0.15) of BSA” should be interpreted as "Loss of skin ≥ 15% (0.15) of BSA" or "Damage of skin ≥ 15% (0.15) of BSA".
  ➢ "Clinical / Laboratory findings improving / unchanged last 24h” should be interpreted as "Clinical findings improving last 24h” or "Clinical findings unchanged last 24h", or "Laboratory findings improving last 24h", or "Laboratory findings unchanged last 24h”.

• 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.

• 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 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, an adult patient is in a SNF bed, but is assigned subacute medical; the Subacute Level II or Level III criteria should be used for review.