Introduction

InterQual® Acute Level of Care Criteria provide support for determining the medical appropriateness of hospital admission, continued stay, and discharge. Acute Adult Criteria address the Observation, Acute, Intermediate, and Critical levels of care. Acute Pediatric Criteria include these levels of care and five additional levels of nursery care (Transitional Care, Newborn Level I, Special Care Level II, Neonatal Intensive Care Level III, and Neonatal Intensive Care Level IV).

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

**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.

1. When evidence in the medical literature to support the effectiveness of an intervention or service is mixed or unclear, the criteria point reflects current best evidence and practice. It is the product of a peer review process involving multiple clinicians with diverse expertise in varied practice and geographic settings.

When conducting reviews, the issue of gender may be relevant. InterQual content contains numerous references to gender. Depending on the context, these references may refer to either genotypic or phenotypic gender. At the individual patient level, a variety of factors, including but not limited to gender identity and gender reassignment via surgery or hormonal manipulation, may affect the applicability of some InterQual criteria. This is most often the case with genetic testing and procedures that assume the presence of gender-specific anatomy. With these considerations in mind, all references to gender in InterQual have been reviewed and modified when appropriate. InterQual users should carefully consider issues related to patient genotype and anatomy, especially for transgender individuals, when appropriate.
Reference materials

Reference materials are provided with the criteria and should be used to assist in the correct interpretation of the criteria.

- **Abbreviations and Symbols List**: Defines acronyms, abbreviations, and symbols used in the criteria.
- **Alcohol Withdrawal Assessment tool**: A worksheet to document a patient’s CIWA-Ar score for alcohol withdrawal.
- **Bibliography**: References cited in the clinical content.
- **Clinical Revisions**: Provide details of changes to InterQual Clinical Criteria.
- **Drug List**: Categorizes drug names and classes mentioned within the criteria.
- **Index**: Lists conditions and/or diagnoses and is designed to guide the user to the criteria subset where a specific condition or diagnosis may be found.
- **Inpatient List**: Identifies procedures that are appropriate for the inpatient setting according to the available evidence or InterQual consultants. (The list is not necessarily in concordance with Medicare’s Addendum E.)
- **InterQual® Transition Plan Tool**: Assists in planning for a safe transition to the most appropriate post-acute level of care.
- **Quality Indicator Checklist**: Contains National Quality Forum’s standard set of hospital quality measures.
- **Care Management Information**: Available in the software for select subsets, Care Management Information outlines the expected clinical progress of each condition and provides suggestions for managing a patient if there are barriers to clinical progression. Care facilitation to the next appropriate level of care is also included. In some subsets, a section for Admission Considerations has been included to identify the types of clinical findings/information that may be used to complete an admission review.

Additionally, the Change Healthcare Customer Hub (http://customerhub.changehealthcare.com) provides interactive support, answers to commonly asked questions, and links to other resources.
How to conduct a review

Conduct an Acute review during the episode of care as follows:

1. Select the most appropriate subset based on the primary condition or working diagnosis.
2. Select the appropriate section of criteria: Initial review or the appropriate episode day. Initial review is used only before the decision to admit has been made.
3. Select a level of care based on the patient’s current or proposed level of care.
4. Select criteria based on the patient’s clinical finding, treatment, and/or service, making sure to meet all criteria, rules, and time parameters. Read all notes and any organizational policies.
5. Take the appropriate action based on the review findings.

Step 1: Select a subset

Select the most appropriate subset based on the condition or working diagnosis. Subset selection should be based on symptoms and findings that are driving the reason for hospital level of care (admission or observation) or continued stay.

InterQual Acute Level of Care Criteria include condition-specific, general, and extended stay subsets.

Condition-specific subsets

If a patient’s condition or diagnosis requiring hospitalization matches one of the condition-specific subsets then select the appropriate subset.

If the patient has a condition, symptom, or finding that is included in a condition-specific subset, it is not appropriate to apply criteria within a general subset.
General subsets

If a patient has a condition, symptom, or finding not addressed in a condition-specific subset, then refer to one of the following general subsets.

If the patient has a condition, symptom, or finding that is included in a condition-specific subset, it is **not appropriate** to apply criteria within a general subset. Redirection links to condition-specific subsets have been added in General subsets to reinforce this process.

**General subsets (Medical)**

**Acute Adult**
- General Medical
- General Trauma

**Acute Pediatric**
- General Medical
- General Trauma

**General Surgical subset**

Surgical subsets are to be used when a patient requires an inpatient surgical or solid organ transplant procedure, or management of a complication related to an ambulatory procedure.

Refer to the Bone Marrow Transplant or Stem Cell Transplant subset to conduct a review for a bone marrow or stem cell transplant.

Criteria for patients who have an ambulatory procedure complication requiring Observation can be found on Operative or Post-op Day 1, under the Observation level of care within the General Surgical subset. For complications requiring treatment at a higher level of care, apply criteria using the Intermediate or Critical level of care. For complications not included in the General Surgical subset, see the most appropriate condition-specific or general subset based on the patient’s symptoms or findings. For example, criteria for wound dehiscence can be found in the General Medical subset.

**Extended Stay subsets**

When the episode days within a condition-specific subset or end-points within a general subset are exhausted and a patient requires continued stay, refer to the Extended Stay subsets.

When using the Extended Stay subsets, consider the following:

- The Extended Stay subset cannot be used on admission.
- The criteria within the Extended Stay subset do not contain specific episode days and may continue to be used until:
  - the designated end points are fulfilled
  - the condition or symptom resolves and responder criteria are met
  - a condition-specific or general subset would be more appropriate (for example, if a patient develops a new condition)

If a patient develops a new condition necessitating continued stay, the reviewer should refer to Episode Day 1 or Operative Day within the most appropriate subset. For example, if an adult patient develops cellulitis during the hospitalization, refer to the Infection: Skin
subset. If a patient requires surgical intervention during the extended hospitalization, refer to the General Surgical subset.

- If criteria are not met within the Extended Stay subset, refer for secondary review.
- Criteria in the Extended Stay subset may be associated with a time-limited endpoint. These endpoints indicate that the criterion may be used for no more than the specified timeframe. For example, in the criterion “Culture pending ≤ 2d,” “≤ 2d” indicates that this criterion can be used for up to (but no more than) two days.

  When the endpoint includes the language “since initiation,” the criterion can only be applied for the total number of days specified and includes the time treatment was delivered in another subset. For example, in the criterion “Anti-infective (includes PO) ≤ 4d since initiation,” “since initiation” indicates that this criterion can be used for up to (but no more than) four days since the initiation of the anti-infective.

- Redirection to the Extended Stay subset is a standard option for patients meeting Non-responder criteria. The Extended Stay subset is comprised of conditions, diagnoses, and symptoms. Occasionally, the actual condition or diagnosis may not be specified in the criteria. For example, criteria for pneumonia are not specified in the Extended Stay subset. The reviewer should look for criteria based on what is driving the patient’s need for continued stay and select criteria under either “Infection” or “Respiratory.” For conditions, diagnoses, or symptoms not addressed in the Extended Stay subset, secondary review is appropriate.

- When changing subsets, begin on Episode Day 1. With a new condition, it is now the first day in the episode of care for that condition.

  For example, a patient is admitted with a COPD exacerbation, but develops chest pain with positive cardiac biomarkers on Episode Day 3. Acute MI is now the patient’s driving condition. The reviewer should conduct a review using Episode Day 1 in the Acute Coronary Syndrome (ACS) subset.

### Step 2: Select Initial review or the appropriate episode day

Select Initial review or the appropriate episode day.

**Initial review**

Some Acute Adult subsets include Initial review criteria. Initial review criteria are a level of care determination tool, intended to be used as real-time decision support in the emergency department to identify if observation or inpatient hospital level services are warranted. They help the reviewer determine whether a patient is appropriate for observation or inpatient admission at the time a decision to admit the patient is being made. Initial review criteria evaluate only data that is available at the time the decision is being made. This may include previously provided interventions or the results of laboratory, imaging, and other tests. Initial review may be appropriate when “bridge” or “holding” orders (e.g., “Admit to telemetry”) are in place. These
orders are intended to address the patient’s needs until full treatment and medication orders are written.

While Initial review enables identification of the level of care, it is not intended to, and should not be used as, a substitute for an Episode Day 1 review, which will generally include specific, evidence-based interventions and intensity of service requirements.

Initial review criteria **should not be used** retrospectively or once the decision to admit has been made (e.g., when full treatment and medication orders have been written). If the reviewer has sufficient information to complete an Episode Day 1 review, an Initial Review need not be performed.

Initial review is used to distinguish between inpatient and Observation and may not be able to differentiate between different inpatient (e.g., Intermediate vs. Critical) levels of care when the level of care is driven by the frequency of an intervention over a span of time.

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**Episode days**

**About episode days**

An episode day is a calendar day, which normally begins at 12:00 a.m. For evening admissions (e.g., after 6 p.m.), Episode Day 1 may represent the admission day (6 p.m.-11:59 p.m.) and the following hospital day.

If conducting daily reviews, the reviewer would conduct the next review using Episode Day 2 criteria. For example, a patient presents to the emergency department on Tuesday evening at 10 p.m. with a severe COPD exacerbation and is admitted. Episode Day 1 criteria are met for admission at the Acute level of care. No review is conducted on Wednesday, because the patient was admitted after 6 p.m. on Tuesday. The next review would be conducted on Thursday using Episode Day 2 criteria. Regulatory or contractual agreements may dictate other specifics concerning when the “new day” begins.

Within a subset, the number of episode days varies by condition; most address common comorbidities and complications associated with the primary condition. Each episode day includes only those levels of care that are clinically appropriate; an episode day may not include all levels of care.

**Conducting a review**

When conducting a review, apply criteria for the appropriate episode day. For example, apply Episode Day 2 criteria on the second day of hospitalization for the same condition.

If the patient’s condition changes at any time during the episode of care, select the appropriate subset for the condition and conduct a review using Episode Day 1. For example:

- A pediatric patient presents to the emergency room with persistent stridor at rest. Conduct the review in the Croup subset using Episode Day 1 criteria.
- If an adult patient is admitted for heart failure, conduct a review in the Heart Failure subset using Episode Day 1 criteria. If the patient rules in for an NSTEMI on Episode Day 2, conduct
As a general rule, conduct reviews moving sequentially through the episode days. The Extended Stay subset does not include specific episode days and is the exception to this rule.

The frequency of review is determined by organizational policy; reviews are not required to be conducted on every episode day.

Practical tips

Some subsets include episode days 2-X or 3-X. Episode Day 2-X or Episode Day 3-X criteria may continue to be used until:

- the condition or symptom resolves and Responder criteria are met
- the designated end points are fulfilled

When designated end points under Partial responder have been fulfilled and the patient does not meet Responder criteria, Non-responder criteria should be applied.

- a new condition arises that drives the need for continued stay

If the patient has a complication or co-morbid condition that is addressed within the current subset, the reviewer should continue to use the subset for the next review. If the patient has a new condition, complication, or co-morbid condition that is not covered within the existing subset, the reviewer should move to a more appropriate subset. For example, if a patient develops bleeding during an admission for a peripheral artery occlusion, the reviewer should continue to use the General Medical subset, because bleeding is included as a complication. (See the Cardiovascular or peripheral vascular criteria.) If a patient develops pneumonia during an admission for a peripheral artery occlusion, the reviewer should use the Infection: Pneumonia subset (Episode Day 1), because pneumonia is not included as a complication in the General Medical subset.

A patient may meet criteria for a specific episode day (in a specific subset) only once; criteria cannot be met for the same episode day on multiple reviews. Exceptions include:

- When a patient is at the Observation level of care and requires an Inpatient level of care for the same condition, you must conduct an Episode Day 1 review using the Acute, Intermediate, or Critical level of care criteria.
- When a patient has met criteria in a condition-specific or general subset and the diagnosis changes, conduct an Episode Day 1 review in the appropriate subset for the new condition.

When conducting a review using a subset that includes more than one condition (e.g., General Medical, Infection: GI/GU/GYN) and the driving condition changes, if the new condition is addressed within the same subset, it would be appropriate to go back to Episode Day 1 and conduct a review using the criteria for the new condition. For example, if a patient is admitted for a alcohol or drug intoxication (found in the General Medical subset) and on Episode Day 3 develops hepatic encephalitis, the reviewer should go back to Episode Day 1 within the General Medical subset and conduct a review.

- When multiple episode days use the same criteria (e.g., Episode Day 7-13), conduct reviews using the same criteria for the range of days specified.
Step 3: Select a level of care

Select a level of care based on the patient’s current or proposed level of care.

Observe the following level-of-care guidelines:

- When a hospital unit’s name (e.g., Progressive Care Unit) does not match the InterQual® levels of care, refer to the level of care definition notes:
  - **Observation**: Hemodynamically stable patients who require 6-24 hours of treatment or assessment pending a decision regarding the need for additional care (excludes ED observation or holding area).
  - **Acute**: Hemodynamically stable patients who require treatment, assessment, or intervention every 4-8 hours.
  - **Intermediate**: Hemodynamically stable patients who require treatment, assessment, or intervention every 2-4 hours.
  - **Critical**: Hemodynamically unstable patients (or those with the potential to become unstable) who require treatment, assessment, or intervention every 1-2 hours.
  - **Newborn Level I**: Patients appropriate at Newborn Level I include physiologically stable neonates who are at least 35 weeks gestational or postmenstrual age, weigh at least 2000 grams, and require evaluation and observation for conditions with low risk for complications or normal newborn care. Level I care also includes neonates who have transferred from a higher level of care or who have been readmitted with conditions such as failure to thrive.
  - **Special Care Level II**: Patients appropriate at Special Care Level II include moderately ill neonates who also may be recovering from an acute illness and no longer require intensive support. These newborns require moderately complex interventions, or have conditions such as apnea of prematurity, the inability to maintain body temperature, or the inability to take oral feedings.
  - **Neonatal Intensive Care Level III**: Neonatal Intensive Care Level III is appropriate for seriously ill, hemodynamically stable neonates who require intensive observation and frequent interventions. Level III care includes mechanical ventilation and other comprehensive services to care for stable newborns, including those who may have complex medical conditions.
  - **Neonatal Intensive Care Level IV**: Neonatal Intensive Care Level IV is appropriate for the most critically ill neonates who are hemodynamically unstable or have a high probability of life threatening deterioration with conditions such as pulmonary hypertension, coarctation of the aorta, pulmonary atresia, gastrochisis, amniocentesis, esophageal atresia, meningomyelocele, or hydrocephalus. These critically ill newborns may have organ failure, require complex surgical interventions or have extremely low birth weight. Level IV offers comprehensive services including advanced respiratory support such as high frequency ventilation, extracorporeal membrane oxygenation/extracorporeal life support (ECMO/ECLS), and surgical repair of serious congenital malformations requiring cardiopulmonary bypass.

- Where a patient is located might not represent the level of care the patient is receiving.
When a patient is located at a place of care that is different from the assigned level of care, use the criteria set aligned with the level of care assignment.

For example, if the patient is in an Acute care bed, but is assigned Observation status, conduct a review using the Observation criteria.

When an infant ≤ 28 days old is admitted to an Acute care facility, the reviewer may use the appropriate level of care within the Nursery subset that corresponds to the severity and intensity of services the infant is receiving, regardless of the location of care.

Within a subset, if the patient has moved or needs to move to a higher level of care for the same diagnosis or condition, conduct the review using the higher level of care for the same episode day. The same process applies when the patient is able to step down to a lower level of care; conduct the review for the same episode day.

The exception to this rule is when the patient is in an Observation level of care. Once in an Observation level of care, if the patient requires care at a higher level or if his or her condition changes, conduct an Episode Day 1 review at the Acute, Intermediate, or Critical level of care. For information about application of the 2 Midnight rule, refer to Step 5.

Higher level of care criteria may be used when the setting has the capability to safely provide the higher level services. For example, if an Acute care unit has the capability to provide Intermediate care (e.g., telemetry), Intermediate level of care criteria can be used to approve care delivery.

Lower level of care criteria may be used to review at a higher level of care when a facility does not have the lower level of care. For example, if a facility does not have an Intermediate care unit and cardiac monitoring cannot be provided on an Acute care unit, then the Intermediate level of care criteria may be applied even though the patient is physically cared for in a Critical care unit.

On occasion, patients who are appropriate at the Acute, Intermediate, or Critical level of care may also meet criteria at a lower level of care. In this situation, apply the higher level of care when clinical documentation supports the need for higher level of care services. This often occurs when an additional finding or risk factor impacts the severity of a condition or when a patient requiring a higher level of care is receiving the standard of care for his or her condition in addition to higher intensity treatments or interventions.

For example, a pregnant patient with pyelonephritis who presents with a temp, abdominal pain, a positive UA, and persistent vomiting would meet criteria in the Observation and Acute levels of care. In this scenario, the patient should be managed at the Acute level of care due to the co-morbid condition of pregnancy.

When a patient is transferred to a new facility, an Episode Day 1 review is not necessary if criteria were met at the transferring facility. The accepting facility should conduct the next review on the appropriate episode day.

For example, a patient was admitted with a STEMI. The following day, he or she is transferred to another facility. Conduct a review for Episode Day 2. When it is not known if criteria was met at the transferring facility the reviewer at the accepting facility could: (1) Conduct a retrospective Episode Day 1 review by applying information found in the transfer summary, report information, or other documentation sent from the original hospital. In this example, the review would be for the date of admission to the transferring (original) facility and is
conducted using information from the patient’s medical record from the transferring facility; (2) Conduct an Episode Day 1 review for the day of transfer to the new facility. In some cases a transfer is done due to worsening symptoms or lack of improvement and it may be possible to conduct an Episode Day 1 review based on these new or worsening symptoms; or (3) Refer the case for secondary review.

Step 4: Select criteria that apply to the case

Consider subset level rules:

- **Time rule:** “Symptom or finding within 24h.”

  “…Symptom or finding within 24h” does not refer to onset; rather, it refers to the presence of the symptom or finding within 24 hours of presentation. Consider the time requirement “Symptom or finding within 24h” when conducting a review. Although criteria must be met during concurrent review, reviews are often conducted retrospectively and all data from the appropriate episode day should be used. Interventions, treatments, and medications are expected to be provided on the episode day they are specified in criteria, unless otherwise noted (e.g., “scheduled or performed within 24h”).

- **Medication rule:** “Excludes PO medications unless noted.”

- **Level of care rule:** Only one level of care can be met for each episode day.

Informational notes within the criteria provide information regarding best clinical practice, new clinical knowledge, explanations of criteria rationale, definitions of medical terminology, and current literature references. A note icon indicates one or more notes are associated with a criteria point.

To view notes, click a note icon.

Select criteria based on the patient's clinical finding, treatment, and/or service.

- If a patient does not meet criteria in the selected subset, then another subset may be more appropriate, additional information may be required, or secondary review may be indicated.

Review available patient-specific clinical information and medical practitioner orders.

Use data from the episode day on which the review is being conducted. This includes information that may have been pending or incomplete at the time the decision to admit was made. When conducting an Episode Day 1 review, emergency room data may be used (e.g., imaging studies, EEG findings, history and physical, medical practitioner orders).

- When doing a prospective review, a scheduled medication order can be applied to the criteria based on the reasonable assumption that the order will be followed. A PRN medication order cannot be applied toward the criteria prospectively, because the reviewer cannot speculate how frequently the patient will require the medication. PRN medications that have been administered can be used when conducting a retrospective review if they meet the frequency specified in criteria.
Responder, Partial responder, and Non-responder criteria

Responder types are as follows:

- **Responder (or Early responder):** Criteria that indicate the patient is clinically stable in the last 12 hours (for adult patients) or 24 hours (for pediatric patients); discharge is expected on the day Responder criteria are selected. The △ symbol indicates that the criteria are not met.

  In some subsets, multiple conditions are combined within the same section of Responder criteria. When conducting a review, the reviewer should select the clinical stability criteria related to the patient’s primary or co-morbid condition. If more than one condition is active, all applicable clinical stability criteria should be selected.

- **Partial responder:** Criteria that indicate the patient is clinically appropriate at that level of care, for the designated episode day and condition.

- **Non-responder:** Criteria that indicate the patient may require continued stay; however, the episode days within the current subset and level of care have been exhausted. The △ symbol indicates that the criteria are not met.

  If a patient meets Non-responder criteria, conduct a review using the Extended Stay subset or refer for secondary review.

When an episode day includes responder types, the reviewer should apply the Responder criteria first. If Responder criteria are not met, then apply Partial responder or Non-responder criteria.

Responder/Non-responder days are based on Length of Stay (LOS) data. In most condition-specific subsets, Responder criteria are introduced on Episode Day 2 and are labeled “Early responder” until one day after the LOS 25th percentile. Once Responder criteria are introduced, from that episode day on, there will always be Responder criteria and either Partial responder or Non-responder criteria. Non-responder days occur one day after the LOS 75th percentile.

The exception to this rule occurs in Episode Days 2-X or 3-X and in the Extended Stay subsets, which include all three responder types on some episode days. Some of the early episode days within a subset may not contain any Responder criteria. Responder criteria will only be present if discharge is clinically expected or reasonable on that episode day. If an episode day does not contain Responder criteria and the patient is stable for discharge, the discharge should still occur.

**Redirection**

In some instances, a reviewer may be redirected from the current subset to a more appropriate subset. Observe the following guidelines for redirection.

- **When a patient’s condition changes and it is clinically appropriate,** the reviewer may be redirected to a more appropriate subset.

  For example, a patient who presents with a deep vein thrombosis (DVT) is found to have a pulmonary embolism (PE) on Episode Day 2. PE is now the patient’s primary condition and the reviewer should use Episode Day 1 in the Pulmonary Embolism subset.

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SOFTWARE NOTE: Automatic redirection to a more appropriate subset may be indicated in the content and/or in a pop-up message.

- When the criteria indicate an alternative subset is more appropriate, criteria in the current subset are not met. If automatic redirection is not included in criteria and the condition changes, select the most appropriate subset and conduct a review.
- Moving to a more appropriate subset based on the clinical condition can occur at any time within the episode of care and should be based on clinical judgment.

For example, if a patient has a medical condition and during the episode of care requires surgery, conduct a review using the General Surgical subset.

### Discharge Screens

When Responder criteria are met, use the Discharge Screens (DS) as needed to assist in determining the most appropriate post-acute level of care. The DS is a resource tool and not criteria. Referring to the DS at the initiation of discharge planning is recommended. DS include ongoing service needs for post-acute levels of care.

SOFTWARE NOTE: Discharge Screens are available at any time during a review.

The DS are organized from the least to most intensive level of care.

There is no time requirement for DS.

For a guide to planning a safe and effective transition to a post-acute level of care, refer to the InterQual® Transition Plan tool. (See “InterQual Transition Plan Tool” on page 16.)

### Process tips

As you conduct a review, observe the following guidelines

- Review all notes, rules, and criteria points.
  - Decision-tree logic requires that the reviewer ensure that each criteria point selected is appropriate. Criteria located below a rule should be selected only when information supporting the upper criteria point is documented in the medical record.

  For example, application of the following nested criteria requires documentation in the patient’s medical record that the patient has dyspnea and a Po2 less than 56 mmHg or an O2 sat less than 89% (0.89):

    Dyspnea, Both:
    
    Oxygenation < baseline, ≥ One:
    Arterial Po2 < 56 mmHg (7.4 kPa)
    O2 sat ≤ 89% (0.89)

  - Select as many criteria as the rule(s) allows within an episode day or as specified by organizational policy for documentation purposes, as long as the minimum number of
criteria has been met. For example, for a rule of “≥ One,” select at least one of the underlying criteria point(s). For a rule of “One,” select only one criteria point.

- Emergency department data can be used to meet criteria on Episode Day 1.
  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 criteria would be appropriate based on the O₂ sat level of 88% (0.88) documented in the emergency department and the ongoing need for oxygen supplementation.

  Medical practitioner orders that were initiated in the emergency room may be used to meet criteria on Episode Day 1.

- When an episode day includes more than one responder type, only one can be met.
- The criteria reflect the minimum standard of care that all patients should receive and do not prevent the performance of other tests or procedures that may be clinically appropriate.
  For example, PCI is not listed as a standard of care in the ACS subset but is often performed on patients who present with acute coronary syndrome (STEMI).

Interpreting criteria

As you conduct a review, observe the following guidelines for interpreting criteria.

- Oxygen saturation (O₂ sat) measurements are based on room air readings, unless the criteria state otherwise.

  At the Intermediate and Critical levels of care, selecting the “Room air assessment not clinically appropriate” criteria point is indicated for those patients who cannot safely tolerate removal of oxygen. Additionally, if a patient remains hypoxic while on oxygen, room air assessment is not required.

- Vital signs are considered sustained findings when they are abnormal for two or more readings greater than 15 minutes apart or are lasting at least 15 minutes. This excludes an isolated reading, a transient abnormal measurement, or a finding that requires urgent treatment (e.g., severe hypoxia, ventricular arrhythmia, or hypotension). Application of criteria for a vital sign finding should be based on confirmatory measurements repeated at regular intervals. Events that are infrequent or vital sign abnormalities that have resolved with outpatient treatment are not considered to be sustained (e.g., the resolution of hypertension following anti-hypertensive therapy or the resolution of tachycardia following rehydration).

  The definition of sustained reflects the opinion of InterQual’s expert clinical consultants. The criteria are based upon current best practice and are the product of an iterative process involving multiple clinicians with diverse expertise in varied practice and geographic settings. When criteria state “within acceptable limits,” this refers to a level or status that is deemed clinically appropriate by the medical practitioner or organization and is reflected in the documentation.
• When criteria state “at baseline,” “> baseline,” or “< baseline,” “baseline” refers to either the patient’s normal baseline or a newly established baseline. In the absence of documentation, a patient’s baseline status may be presumed to be normal.

• Some criteria points are associated with a time-limited endpoint. For example, “Culture pending ≤ 2d.” The end point “≤ 2d” indicates that the criteria point may be applied for no more than two days.

• “Hospital acquired” refers to a condition that developed during the patient’s current hospitalization. Criteria referring to conditions that were acquired during the current hospitalization cannot be applied for patients who have been discharged to home or transferred to a post-acute facility.

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**Step 5: Take action based on review findings**

Take the appropriate action based on the review findings, depending on whether the patient’s case is impacted by the CMS 2-Midnight Rule.

**Without the CMS 2-Midnight rule**

For patients who are not impacted by the CMS 2-Midnight Rule, take action as follows:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
</table>
| Initial review met | Level of care met  
  - Approve recommended level of care.  
  - Conduct Episode Day 1 review when full medication or intervention orders are available. |
| Episode day criteria or Partial responder met | Level of care met  
  - Approve level of care for that episode day.  
  - Schedule next review. |
| Responder met | Level of care not met  
  - Prepare for discharge. Review Discharge Screens to determine appropriate post-acute level of care. |
| Non-responder met | Level of care not met  
  - Select Extended Stay subset and conduct review or refer for secondary review. |
### Finding: Episode day criteria, Responder, Partial responder, and Non-responder not met

**Level of care not met:**
- Obtain additional information from attending medical practitioner or other caregivers.
- If additional information does not support criteria, discuss condition with medical practitioner. (An alternate setting may be more appropriate for managing the patient’s condition.)
- Facilitate transfer if medical practitioner is agreeable to alternate setting or level of care.
- Refer for secondary review if medical practitioner does not agree.

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### With the CMS 2-Midnight Rule

For Medicare beneficiaries who are impacted by the CMS 2-Midnight Rule, take action as follows:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physician expects care to span 2 or more midnights</td>
<td>Apply Episode Day 1 Inpatient criteria in the appropriate subset.</td>
</tr>
<tr>
<td>Attending physician is undecided as to whether or not care will span 2 midnights</td>
<td>Apply Episode Day 1 criteria in the appropriate subset to determine the level of care based on medical necessity. Depending on which level of care is met, determine whether the patient is an inpatient or assign Observation status.</td>
</tr>
<tr>
<td>Attending physician expects that care will span less than 2 midnights</td>
<td>Apply Episode Day 1 Observation criteria in the appropriate subset and then proceed with the actions below for continued stay. If Observation criteria are not met but Inpatient criteria are met, it may be appropriate to initially assign a status of Observation.</td>
</tr>
</tbody>
</table>
Patients who are in Observation beyond one midnight and it is expected the patient will require care beyond the second midnight (e.g., does not meet Observation Responder criteria)

Apply Episode Day 2 criteria in the appropriate subset.

**Note:** CMS requirements for “hospital-based services” can be determined by applying criteria at the Observation, Acute, Intermediate, or Critical level of care. Patients who meet Observation criteria by demonstrating that they require hospital-based services will satisfy CMS’s requirement for Inpatient status. For example, a patient meeting Partial responder criteria at the Observation level of care on Episode Day 2 would be considered an inpatient once he or she has crossed the second midnight of care.

For complications of an ambulatory surgery or procedure, apply Post-op Day 1 criteria in the General Surgical subset.

Patients who are in Observation beyond the second midnight (Episode Day 3) and who do not meet Observation responder criteria

Apply Episode Day 3 Inpatient criteria in the appropriate condition-specific or general subset.

**Note:** Patients who meet criteria at the Inpatient level of care would continue to be considered an inpatient; those who do not meet criteria would be appropriate for secondary review.

If medical necessity is not met, follow the standard review process. (See “How to conduct a review” on page 3.)

In certain situations, an attending physician may expect care to span less than 2 midnights; however, Inpatient admission may be appropriate. Such situations include, but are not limited to, medically necessary procedures on the CMS Inpatient Only list; new-onset mechanical ventilation (not short term for a surgery); and any other situations approved by CMS in sub-regulatory guidance. For patients who were expected to stay in the hospital for more than 2 midnights, but who have an unforeseen circumstance and stay less than 2 midnights (e.g., quick recovery, transfer, death, election of hospice), the organization decides how to manage the patient’s status. InterQual Criteria can assist only in providing guidance on the medical necessity of an episode day at a particular level of care.

Benchmark Length of Stay Powered by RelayHealth Financial

Benchmark length of stay (LOS) information is included in Acute Adult and Pediatric Criteria for most conditions. LOS values are derived from a select set of claims data from RelayHealth.
Financial and have been statistically validated. Values represent geometric mean length of stay for a specific condition and are based on ICD claims including co-morbidities. For conditions with more than one ICD code (e.g., NSTEMI), the LOS represents a weighted average based on the number of claims for each included ICD code. Additionally, in the Adult content, the Centers for Medicare & Medicaid Services Medicare Severity Diagnosis Related Groups Geometric Mean Length of Stay (CMS MS-DRG GMLOS) is provided. The LOS values create guidance designed to facilitate efficient management of a patient to a target.

InterQual Transition Plan Tool

The InterQual Transition Plan tool is a guideline to assist 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 for readmission
- Provides a framework for identifying discharge needs

Secondary review

Secondary review determines the appropriateness of the current or proposed level of care when it is not supported by criteria on primary review. Secondary reviewers may include a supervisor, specialist (e.g., therapist, wound or ostomy nurse), or medical practitioner. A medical practitioner is not required to perform a secondary review. Organizational policy should dictate the extent to which secondary review is performed to render a review outcome.

The secondary reviewer determines medical necessity based on review of the medical record; discussions with nursing staff, the discharge planner, and the attending medical practitioner; and clinical knowledge. The secondary reviewer may refer to the criteria when making their determination, but is not required to apply criteria as part of the secondary review process.

When is a secondary review appropriate?

- Review criteria are not met.
- Criteria are met and there is a concern about the level of care based on the complexity of the patient’s condition.
- There are questions about the quality of care.
- As identified by the organization.
What questions does a secondary review address?

- Does the patient require admission or continued hospitalization?
- 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 steps

1. The secondary reviewer determines medical necessity based on review of the medical record; discussions with members of the interdisciplinary team (e.g., nursing staff, the discharge planner, therapists, and the attending medical practitioner); and clinical knowledge.

2. If the secondary reviewer agrees with the existing level of care, approve the level of care and schedule the next review.

3. 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 setting or level of care, if available.
   - If the attending medical practitioner does not agree with the secondary reviewer, initiate action as indicated by organizational policy.

4. If the alternate level of care is unavailable or inappropriate based on the findings of the secondary reviewer, record the number of variance days and the reason for the variance.

5. Document the review outcome.

Variance days

A “variance day” is a day of care at a higher level of care than is necessary based on the review. When Discharge Screens are met and a lower 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 appropriate alternate level of care, 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 level is appropriate.

4. Discuss the case with a secondary reviewer and document the review decision.