InterQual® Level of Care Criteria
Long-Term Acute Care Criteria

Review Process

Introduction

InterQual® Level of Care Criteria support determining the appropriateness of Long-Term Acute Care (LTAC) admission, continued stay, and discharge destinations for patients who are 18 years of age and older.

For Medicare beneficiaries, CMS’s IPPS standard LTAC payment rate is based on one of the following patient-level clinical conditions:

The patient’s stay in the LTAC was immediately preceded by a discharge from an acute care hospital that included at least three days in an intensive care unit (ICU).

The patient’s stay in the LTAC was immediately preceded by a discharge from an acute care hospital and the patient’s LTAC stay is assigned to an MS–LTC–DRG based on the receipt of ventilator services for at least 96h.

Patients who do not meet these conditions may still be clinically appropriate for LTAC level services. You can use InterQual Criteria to help determine medical necessity. The IPPS standard LTAC payment policy is related to reimbursement, not determination of medical necessity. 

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.

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.
- 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.
• **InterQual® Transition Plan Tool:** Assists in planning for a safe transition to the most appropriate post-acute level of care.

Additionally, MHS Customer Hub ([http://mhscustomerhub.mckesson.com](http://mhscustomerhub.mckesson.com)) provides interactive support, answers to commonly asked questions, and links to other resources.

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**Informational notes**

Informational notes 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.

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**How to conduct a review**

Long-Term Acute Care Criteria include four types of reviews: Preadmission, Admission, Continued Stay, and Discharge. Each type of review uses criteria components to determine the appropriateness of the level of care. There are three components:

- **Severity of Illness (SI):** Used to determine the severity of the patient’s illness.
- **Intensity of Service (IS):** Represents monitoring and therapeutic services that can be administered at the specified level of care.
- **Discharge Screens (DS):** Used to determine whether the patient has reached a level of stability or independence appropriate for a safe discharge or transfer from the current level of care.

The following sections explain the process for conducting each type of review. As you conduct a review, observe the following guidelines:

- Review all notes attached to criteria subsets, rules, and criteria points.
- You may select as many criteria as the rules 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,” you can select one or more underlying criteria points. When the rule displays as “One,” you should select only one criterion.
- Sometimes when you select criteria with a rule of “All,” the underlying criteria points will automatically be selected. This feature is intended to enhance usability. However, it is essential that all of the underlying criteria points are met and notes are reviewed before you select the parent criteria point. This functionality is enabled based on organizational preference.
- Criteria that state “at baseline,” “> baseline,” or “< baseline” refer to the patient’s pre-illness or new baseline status.

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**Preadmission review**

Conduct a Preadmission review to determine the appropriateness of an admission prior to a planned admission or transfer to a level of care. A Preadmission review uses the Severity of Illness (SI) criteria (Refer to page 8 for more information about Severity of Illness).
To conduct a Preadmission review, follow these steps:

1. Identify the level of care based on the patient’s current or proposed level. Observe these guidelines:
   - When a facility’s name (for example, 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, you should use the criteria set aligned with the level of care assignment. For example, suppose a patient is in an LTAC bed but is assigned subacute medical. Use Subacute criteria for the review.

2. Select the appropriate subset based on the patient’s predominant presenting clinical findings.

3. Obtain and review patient specific clinical information (for example, history, physical, laboratory, imaging, ECG finding, progress notes, and medical practitioner orders).

4. To apply the SI rule, select 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.

   **Important:** The SI criteria require one primary condition and two active comorbid conditions be selected. *(Note: Exceptions to this rule are the Ventilator Weaning subset where selection of an active comorbid condition is not required and the Wound/Skin subset that requires management and treatment of one active comorbid condition). The comorbid condition(s) can only be selected when they affect the patients’ medical status necessitating skilled assessment, active medical treatment and intervention during the LTAC stay. Duplication of selected SI criteria should not occur between primary and comorbid conditions.

   For example:

   If the patient’s primary reason for admission is pneumonia, then “Infection with systemic manifestation ≤ 30d” should not be selected as a comorbid condition.

   As you conduct the review, observe the following guidelines:

   - Oxygen saturation (O₂ sat) measurements are based on room air readings unless the criteria state otherwise. Criteria that state “within normal limits (WNL)” or “within acceptable range” refer to a level or status that is deemed clinically appropriate by the medical practitioner or organization.

5. Take action, as follows:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission rule met</td>
<td>Approve planned admission.</td>
</tr>
</tbody>
</table>
**Finding** | **Action**
--- | ---
Preadmission rule not met | • Contact the attending medical practitioner for additional information to verify the need for admission to the LTAC level of care.
• If the additional information satisfies the preadmission rule, approve the planned admission.
• If the additional information does not satisfy the preadmission rule, refer for Secondary review. See the Secondary review process section on page 10.

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### Admission review

Conduct an Admission review when a patient is admitted to a level of care or transferred to a higher level of care. The Admission review determines the appropriateness of that level of care. Apply the Severity of Illness (SI) criteria and Intensity of Service (IS) criteria derived from the first 48 hours of admission. (Refer to page 8 for more information about Severity of Illness criteria and Intensity of Service criteria.)

To conduct an Admission review, follow these steps:

1. **Identify the level of care** based on the patient’s current or proposed level. Observe these guidelines:
   - When a facility’s name (for example, 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, you should use the criteria set aligned with the level of care assignment. For example, suppose a patient is in an LTAC bed but is assigned subacute medical. Use Subacute criteria for the review.

2. **Select the appropriate subset** based on the patient’s predominant presenting clinical findings.

3. **Obtain and review patient specific clinical information** (for example, history, physical, laboratory, imaging, ECG finding, progress notes, and medical practitioner orders).

4. **To apply the SI rule,** select criteria based on the patient's clinical findings, making sure to meet all the rules for time of onset and number of criteria.

**Important:** The SI criteria require **one** primary condition and **two** active comorbid conditions be selected. *(Note: Exceptions to this rule are the Ventilator Weaning subset where selection of an active comorbid condition is not required and the Wound/Skin subset that requires management and treatment of one active comorbid condition). The comorbid condition(s) can only be selected when they affect the patients’ medical status necessitating skilled assessment, active medical treatment and intervention.
during the LTAC stay. Duplication of selected SI criteria should not occur between primary and comorbid conditions.

For example:

If the patient’s primary reason for admission is pneumonia, then “Infection with systemic manifestation ≤ 30d” should not be selected as a comorbid condition.

As you conduct the review, observe the following guidelines:

– Oxygen saturation (O2 sat) measurements are based on room air readings unless the criteria state otherwise.
– Criteria that state “within normal limits (WNL)” or “within acceptable range” refer to a level or status that is deemed clinically appropriate by the medical practitioner or organization.
– PRN medication can be used to meet the IS criteria during an Admission review when actual administration can be determined and the required frequency (for example, 3x/24h) is met.

5. To apply the IS rule, expand the Admission criteria section. Select criteria based on the prescribed treatments, medications, or interventions from the same criteria subset that you used to select SI, making sure to meet all the rules for duration and number of criteria.

– When there is a range of days (for example, ≤ 2d) associated with an IS criterion, you may approve up to the time frame, eliminating the need for weekly or daily review. The end point “≤ 2d” indicates that the criteria point may be applied for no more than two days.

**Important:** IS criteria require selection of two comorbid conditions, in addition to the interventions listed for the primary condition or illness.

**Note:** Exceptions to this rule are the Ventilator Weaning subset where selection of an active comorbid condition is not required and the Wound/Skin subset that requires management and treatment of one active comorbid condition. Duplication of selected IS criteria should not occur between the primary and comorbid conditions.

**Example:**

When “Renal failure” is selected under the primary condition section, then “Dialysis or ultrafiltration” in the comorbid treatment section cannot be selected

6. Take action, as follows:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
</table>
| SI and IS rules met | • Approve admission to level of care.  
|                   | • Schedule Continued Stay review.                                      |
| 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 the Secondary review process section on page 10. |
Continued Stay review

Conduct a Continued Stay review to determine the appropriateness of continued stay at the current level of care. Apply the Intensity of Service (IS) criteria to the review. (Refer to page 8 for more information about Intensity of Service criteria.)

Important: A Continued Stay review should be conducted at least weekly. Though, the review frequency may vary based on organizational policy. Each time you conduct a Continued Stay review, evaluate the case since the last review to ensure the Intensity of Service (IS) has been met daily.

To conduct a Continued Stay review, follow these steps:

1. Select the same criteria subset that was used for the admission review, with the following exceptions:
   - The patient is transferred to a higher level of care. In this case, conduct an Admission review. Apply both SI and IS criteria 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. In this case, you can use a different subset within that level of care. Apply only IS criteria.

2. Obtain and review patient specific clinical information (for example, medical practitioner, nursing, therapy, and interdisciplinary team progress notes, medical practitioner orders, medication and treatment records).

3. To apply the IS rule, expand the Continued Stay section. Select a responder type based on the prescribed treatments, medications, or interventions from the same criteria subset that you used to select SI, making sure to meet all the rules for duration and number of criteria. Responder types include:
   - 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 🚫 symbol.
   - Partial responder: Criteria that indicate the patient is appropriate for continued stay.

Important: The Partial responder criteria require selection of two comorbid conditions in addition to the interventions listed for the primary condition or illness. Avoid selecting similar criteria for the primary and comorbid conditions. For example:

If renal failure is selected as the primary condition, then “Dialysis or ultrafiltration” should not be selected as a comorbid condition.

This rule does not apply to the Ventilator Weaning subset and the Wound / Skin subset.

As you conduct the review, observe the following guidelines:
Review Process

- Oxygen saturation (O₂ sat) measurements are based on room air readings unless the criteria state otherwise.
- Criteria that state "within normal limits (WNL)" or "within acceptable range" refer to a level or status that is deemed clinically appropriate by the medical practitioner or organization.
- When there is a range of days (for example, ≤ 2d) associated with an IS criterion, you may approve up to the time frame, eliminating the need for weekly or daily review. The end point “≤ 2d” indicates that the criteria point may be applied for no more than two days.

4. Take action, as follows:

<table>
<thead>
<tr>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS Partial responder met</td>
<td>• Approve level of care.</td>
</tr>
<tr>
<td></td>
<td>• Schedule next Continued Stay review.</td>
</tr>
<tr>
<td>IS Responder met</td>
<td>Prepare for discharge or transfer. Review discharge screens to determine the most appropriate post-acute level of care.</td>
</tr>
<tr>
<td>IS Partial responder and Responder not met</td>
<td>• Obtain additional information from the attending medical practitioner or other caregivers.</td>
</tr>
<tr>
<td></td>
<td>• If IS still not met, conduct discharge review. See the Discharge review process section on page 7.</td>
</tr>
</tbody>
</table>

**Discharge review**

Conduct a Discharge review when criteria for continued stay are not met. A Discharge review assists you in determining the next appropriate level of care within the facility (a transfer to another unit) or in determining discharge from the facility. A Discharge review uses the Discharge Screens (DS) criteria (Refer to page 8 for more information about Discharge Screens.)

**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.

To conduct a Discharge review, follow these steps:

1. Select the same criteria subset that was used for the Admission or Continued Stay review.
2. Apply the DS rule for the appropriate level of care.
3. Take action, as follows.
<table>
<thead>
<tr>
<th>Review reason</th>
<th>Finding</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS Partial responder not met or IS Responder and Partial responder not met</td>
<td>DS met</td>
<td>• If discharge is scheduled, no action required.</td>
</tr>
<tr>
<td></td>
<td>DS not met</td>
<td>• If discharge is not scheduled:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Contact the attending medical practitioner to discuss the discharge plan and alternate level of care options.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Facilitate discharge or transfer if the attending medical practitioner agrees.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>– Refer for Secondary review if the attending medical practitioner does not agree with the alternate level of care. See the Secondary review process section on page 10.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer for Secondary Review if the attending medical practitioner does not agree with the alternate level of care. See the Secondary review process section on page 10.</td>
</tr>
</tbody>
</table>

**Documenting variances**

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

1. Indicate the reason the patient has not been transferred.
2. Assign a level of care that represents the level of care that would be appropriate for the patient if 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.

**InterQual Level of Care components**

Level of Care components screen the appropriateness of admission to, continued stay at, and discharge from care. There are three components:

- Severity of Illness (SI)
- Intensity of Service (IS)
- Discharge Screens (DS)

**Severity of Illness**

Severity of Illness (SI) criteria consist of objective clinical indicators.

- The SI rule requires that all SI criteria be met.
- The time requirement for onset of symptoms in all criteria subsets is:
  - In lieu of Acute or continued hospitalization
  - Failed Alternate Level of Care
- These requirements assume that the Long-Term Acute Care level of care is either substituting for continuation of care at a higher level (for example, acute care, intensive care) or that there has been
a past history of attempting care at a lower level (for example, subacute, SNF, home care) with a high rate of recidivism.

- The clinical indicators include the patient’s illness, clinical stability, and why services are precluded at a lower level of care. In addition, the Ventilator Weaning subset includes indicators for weaning potential since this is the goal of admission.
  - All criteria subsets include criteria that address the need for continued medical management of a primary condition or illness in addition to the management and treatment of two active comorbid conditions. Exceptions to this rule are the Ventilator Weaning subset, in which selection of an active comorbid condition is not required, and the Wound / Skin subset, which requires management and treatment of one active comorbid condition.

### Intensity of Service

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.
  - **Responder**: Criteria that indicate the patient is appropriate for discharge. Selection of these criteria “do not meet” for continued stay and are denoted by a \( \triangle \) symbol.
  - **Partial Responder**: Criteria that indicate the patient is appropriate for continued stay. The patient has the potential for continued medical and/or functional improvement.

- The IS time requirement is “At Least Daily.”
- Some IS criteria are associated with a duration of time, which are intended to allow you 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 (for example, after 6 p.m.). In this case, day one would not begin until the next day.

Regulatory or contractual agreements may dictate other specifics concerning when the “new day” begins. For example:

“IV fluids \( \geq 75\text{mL/h}, \leq 3\text{d} \)” If the patient was started on IV fluids late in the evening on a given day, then the first day of counting for IV fluids would start the next morning.

### Discharge Screens

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

- The DS rule requirement is One.
- The DS are organized from the least intensive alternate level of care to the most intensive alternate level of care.
InterQual® Transition Plan tool

The Transition Plan tool assists you in planning for a patient’s safe transition to the most appropriate post-acute level of care. You 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

When a case does not meet criteria, it is referred for a secondary review. A supervisor, a specialist (for example, therapist, chiropractor), or a physician may conduct a secondary review. It is a matter of organizational policy to determine the qualifications of the reviewers as well as the extent to which secondary reviews are performed 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 the provider and referring physician, and by applying clinical experience.

A Secondary review is appropriate when review rules are not met, and when you have questions about the quality of care. A Secondary review addresses the following questions:

- 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?

To conduct a Secondary review, follow these steps:

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 the 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 indicated by organizational policy.
3. If the alternate level of care is unavailable, finalize the Variance Code.
4. Document the review outcome.