INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS
ORGANISATION

The InterQual Rehabilitation Criteria cover adult, senior, and Paediatric populations. The Adult Criteria are organised into Acute and Subacute subsets. The Senior subset covers the adult population and addresses the thirteen medical conditions identified by CMS as the most appropriate for the acute rehabilitation setting. The Paediatric subset covers Acute Rehabilitation.

AGE PARAMETERS

Adult Rehabilitation Criteria, Senior Rehabilitation Criteria, and Subacute Criteria are for the review of patients > 17 years of age. The Paediatric Acute Rehabilitation Criteria are for patients ≤ 17 years of age.

LEVEL OF CARE COMPONENTS

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.
  
  Examples:
  - Illness / Injury / Surgery ≤ 30 days
    (Adult and Paediatric Rehabilitation)
  - Illness / Injury / Surgery / Exacerbation / Co-morbid Condition
    (Senior Rehabilitation)
- SI criteria address:
  - The clinical features of the patient’s illness appropriate for the specific level of rehabilitation care.
  - Patient’s ability and willingness to benefit from a comprehensive 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 One IS criteria be met.
- 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 attached to the criterion. For example:
  - Discharge review, one:
    - Ø Functional plateau reached / Minimal functional gains ≥ 1wk (HC / SNF / SAC, ≥ one):
    - Ø Prior level of function achieved (Home / OP)
    - Ø Rehabilitation goals met (Home / OP)
- 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 ≥ 3h/d ≥ 5d/wk (Adult and Paediatric Rehabilitation)
  - At least 1 discipline ≥ 3h/d ≥ 5d/wk (Senior Rehabilitation)
  - At least 2 disciplines ≥ 2-3h/d ≥ 5d/wk (Subacute Rehabilitation)
INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

• Some IS criteria are associated with a duration of time, which are intended to allow the
to 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 ≤ 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 organised by alternate levels of care as suggested by the care facilitation IS.

• The DS rule requires One: ALOC
• The Rehabilitation level DS are organised 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.

PREADMISSION REVIEW

Preadmission Review Rule
To perform a Preadmission Review, the SI criteria need to be applied before admission.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Time</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission</td>
<td>Before admission</td>
<td>Apply Severity of Illness (SI)</td>
</tr>
</tbody>
</table>

Preadmission Review Steps
1. Identify the level of care based on the proposed level and the patient’s rehabilitation needs.
2. Obtain and review patient specific clinical information: (e.g., history, physical, laboratory,
imaging, ECG findings, progress notes, and medical practitioner orders).
3. Select the most appropriate criteria subset based on the patient’s predominant clinical findings
   and rehabilitation needs.
4. Apply SI rule.
   • Select SI criteria based on the patient’s clinical findings and rehabilitation needs. Determine if
     All criteria are met.
   • Document the SI criteria points met.
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>SI met</td>
<td>• Approve planned admission.</td>
</tr>
</tbody>
</table>
| SI not met                | • Contact the attending medical practitioner for additional information to verify the need for admission to the Acute or Subacute Rehabilitation setting.  
• If the additional information satisfies the SI rule, the planned admission may be approved.  
• If the additional information does not satisfy the SI rule, refer for Secondary Review. (For information about the Secondary Review process, refer to page RP-10). |

**Practical Tips**

- If you are having difficulty determining the appropriate level of care, refer to the Level of Care Notes. These notes are located on the title page of each criteria subset. When a rehabilitation facility’s name (e.g., Rehabilitation Centre) does not match the criteria subset levels (e.g., Acute Rehabilitation, Subacute Rehabilitation), the Level of Care Notes describe the minimum requirements for clinical stability and facility specific capabilities generally provided at the specific level of care.
- When you are having difficulty locating criteria, refer to the Index.
- Remember to check for the SI time requirement before selecting criteria.
- You may select as many SI as you wish, or as specified by your organisation for documentation purposes, as long as the minimum number of criteria required has been met.
- You cannot apply Subacute Rehabilitation criteria to validate an admission to an Acute Rehabilitation level of care due to a lack of availability of the Subacute Rehabilitation level of care unless previously agreed upon by all pertinent parties in the healthcare system.

**ADMISSION REVIEW**

**Admission Review Rule**

To validate the admission to a rehabilitation level of care, both the SI rule and the IS rule from the same criteria subset must be met.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Time</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>Review data derived from first 48 hours of admission</td>
<td>Apply Severity of Illness (SI) and Intensity of Service (IS)</td>
</tr>
</tbody>
</table>

**Admission Review Steps**

1. Identify the subset based on the proposed level and the patient’s rehabilitation needs.
2. Obtain and review patient specific clinical information: (e.g., history, physical, laboratory, imaging, ECG findings, progress notes, and medical practitioner orders).
3. Select the most appropriate criteria subset based on the patient’s predominant presenting clinical findings and rehabilitation needs.
4. Apply SI rule.
   - Select SI criteria based on the patient’s clinical findings and rehabilitation needs. Determine if All criteria are met.
   - Document the SI criteria met.
5. Apply IS rule.
   • Select IS criteria based on prescribed rehabilitation program from the same criteria subset used to select SI and determine if All criteria are met.
   • Document the IS criteria met.

6. Continue according to the following recommended actions.

### Admission Review Actions

<table>
<thead>
<tr>
<th>For these Review Findings</th>
<th>Do this</th>
</tr>
</thead>
</table>
| SI and IS rule met        | • Approve admission to level of care.  
                           | • Schedule Continued Stay review. |
| SI or IS rule not met     | • Obtain additional information from the attending medical practitioner or other caregivers.  
                           | • If additional information does not meet the corresponding SI or IS, discuss alternate levels of care with attending medical practitioner.  
                           | • Facilitate transfer if attending medical practitioner agrees with alternate level of care.  
                           | • Refer for Secondary Review if attending medical practitioner does not agree with alternate level of care. (For information about the Secondary Review process, refer to page RP-10.) |

### Practical Tips

- Remember to check the time requirements for both SI and IS before selecting criteria.
- If a Ø IS is selected on an admission review, the patient will not meet criteria for admission to the Rehabilitation level of care. The reviewer should review the DS screens to evaluate specific alternate levels of care that can provide the necessary services to meet the clinical needs of the patient.
- You may select as many SI and IS as you wish, or as specified by your organisation for documentation purposes, as long as the minimum number of criteria required has been met.
- Sometimes, where the patient is physically located is different from the location implied by the level of care assignment (e.g., the patient is in an acute rehabilitation bed, but is receiving subacute rehabilitation level of care). When this situation occurs, the reviewer should apply the criteria covering the patient’s assigned status or level (e.g., Subacute Rehabilitation).
INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

CONTINUED STAY REVIEW

Continued Stay Review Rule
To validate the continued stay, the reviewer applies the IS criteria.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Time</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continued Stay</td>
<td>At least weekly</td>
<td>Apply Intensity of Service (IS)</td>
</tr>
</tbody>
</table>

IMPORTANT: Continued Stay Review should be performed at least weekly, however, this may vary based on organisational 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. 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).
2. 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 or rehabilitation condition has changed, then the reviewer may use a different subset within that level of care and would only need to apply IS criteria.
3. Apply IS Rule.
   - Select IS criteria to determine if the rule is met.
   - Document the IS criteria met.
4. Continue according to the following recommended actions.

Continued Stay Review Actions

<table>
<thead>
<tr>
<th>For these IS 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 next review.</td>
</tr>
<tr>
<td>IS not met</td>
<td></td>
</tr>
<tr>
<td>IS and discharge review selected</td>
<td>• Obtain additional information from the attending medical practitioner or other caregivers. If IS still not met, perform discharge review. See Discharge Review* on page RP-8</td>
</tr>
</tbody>
</table>

Copyright ©2008 McKesson Corporation and/or one of its subsidiaries. All rights reserved.
INTERQUAL® REHABILITATION CRITERIA
REVIEW PROCESS

Practical Tips

- Before selecting criteria, remember to check the IS time requirement.
- When there are a range of days associated with an IS criterion, the rules allow the reviewer to approve up to the time frame (≤3d) without having to review the case each day/week. Based on the patient’s clinical status, the reviewer may question whether continued services could be received at an alternate level of care before the end of the time frame. When the IS is met and there is a range of days, the reviewer can apply the discharge screens (DS) criteria to validate that the patient is safe for transfer (discharge).
  - If DS are not met or the alternate level of care is unavailable, continued stay at the current level should be approved.
  - If the DS are met and the alternate level of care is available, the reviewer should discuss the case with the attending medical practitioner. If the medical practitioner agrees, facilitate transfer.

DISCHARGE REVIEW

Discharge Review Rule

A reviewer conducts a Discharge Review when the IS rule is no longer met. The Discharge Screens are designed for reviewing multiple levels of care to determine the most appropriate level of care for the patient.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Review Time</th>
<th>Review Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge</td>
<td>When IS not met or on discharge</td>
<td>Apply Discharge Screens (DS)</td>
</tr>
<tr>
<td>IS and discharge</td>
<td>IS and discharge review selected</td>
<td>Apply Discharge Screens (DS)</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 and Continued Stay Review
   - Apply DS rule: One: ALOC
   - Determine the most appropriate ALOC
   - Apply the level of care appropriateness
   - Apply the clinical stability criteria associated with the level of care
   - Document findings
2. Continue according to the following recommended actions.
## Discharge Review Actions

<table>
<thead>
<tr>
<th>For this discharge review reason</th>
<th>With these discharge review findings</th>
<th>Do this</th>
</tr>
</thead>
</table>
| IS not met / IS and discharge review selected | DS met | A. If discharge is scheduled, no action required.  
B. If discharge is not scheduled:  
  ➢ Contact the attending medical practitioner or other caregiver to discuss the discharge plan and alternate level of care options.  
  ➢ Facilitate transfer if the attending medical practitioner agrees with an alternate level of care.  
  ➢ Refer for Secondary Review if attending medical practitioner does not agree with the alternate level of care. (For information about the Secondary Review process, refer to page RP-10.) |
| IS not met / IS and discharge review selected | DS not met | • Contact the attending medical practitioner or other caregiver to discuss the treatment, discharge plans, and alternate level of care options, if appropriate.  
• Facilitate transfer if the attending medical practitioner agrees with an alternate level of care.  
• Refer for Secondary Review if attending medical practitioner does not agree with the alternate level of care. (For information about the Secondary Review process, refer to page RP-10.) |

### DOCUMENTING VARIANCE DECISIONS

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

When a case does not meet criteria, it is referred for a Secondary Review. A supervisor, a specialist (e.g., therapist, wound / ostomy nurse) or a medical practitioner may conduct secondary review. Organisational policy should determine the qualifications of the reviewers as well as the extent to which secondary review(s) is performed in order to render a review outcome. The secondary reviewer determines the medical necessity of admission or continued stay based on review of the medical record, discussions with nursing, discharge planner, and attending medical practitioner, and by applying clinical experience.

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, the reviewer 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 approved by organisational policy.
- If the alternate level of care is unavailable, finalise the Variance Code.
- Document the review outcome.

IMPORTANT: The Criteria reflect clinical interpretations and analyses and cannot alone either resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient.