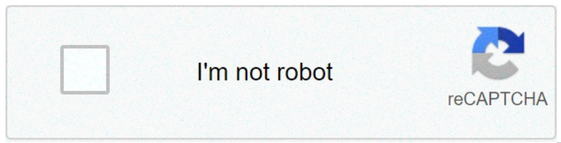

Continue

What are interqual and milliman care guidelines

Ross, who has in the past served as an adviser to the CMS on observation status, offered the example of an elderly Medicare patient who comes to a hospital emergency room complaining of back pain.Such patients meet “every criteria I can think of” for inpatient admission, he says, yet InterQual criteria advise against admitting back-pain patients. “This is one area, and I'm sure there are more, where there is really a disconnect between the evidence and what is being imposed on the public by the admission-criteria vendors,” Ross says. “They are setting a standard that the payers are using to deny payment to hospitals. And because of RAC audits, I know of several hospitals that are admitting every patient into observation for 24 hours while they sort out their status.”Mike Todai, president and CEO of the consulting firm Hospital Case Management in Signal Mountain, Tenn., says physicians have strong feelings about the admissions criteria, which are not taught in medical schools and are applied retroactively by nonphysicians.“They hate it,” Todai says. “Because they know their patient, they know their community, and what they can or cannot do. … Their goal is to take care of a patient.”But defenders of the admissions criteria take every opportunity to stress that the systems are not intended to dictate what physicians should do. Rather, advice from InterQual and Milliman is intended to be guidance based on objective criteria and observed patient symptoms.“They're designed as a tool to help with that decision. They don't make the decision for you,” says Dr. Garrett Foulke, senior editor in the care guidelines division of Milliman.In an e-mailed statement, a spokeswoman for Community Health Systems reiterated a statement she said was not new: “The decision about whether to admit, observe or discharge a patient is a clinical assessment made by a physician. In making these decisions, physicians rely on their education, training and experience and a clinical assessment of the individual patient.”Milliman's Foulke acknowledged that the RAC audits of hospital inpatient admissions have had the effect of sharpening hospitals' attention to the criteria, to the point that many hospital officials want to put the evidence-based criteria “into the hands of the people in the hospital, and have them be used in a real-time basis, rather than a retrospective basis.”Foulke also says it's true that most physicians don't know all of the admission criteria, even though they play a critical role in determining whether hospitals get paid for the care. “Our solution to that is that these criteria ought to be available at the time the decision is being made at the hospital,” he says.That could be done by tying it directly into patient EHRs at the point of care. He says Milliman was already working toward an “embedded solution” such as that.Officials with McKesson, owner of InterQual, declined interview requests for this story, but in response, a spokeswoman provided copies of articles on the use of the tools in evidence-based medicine. One 2008 article, “The Birth of InterQual” in the journal Professional Care Management, noted that systems like InterQual were explicitly designed to change physicians' entrenched practices: “The history of InterQual continues to be written, but what it has achieved in its 30-year history is a remarkable reminder to everyone working in healthcare today that even a few dedicated individuals can transform the industry for the better. All it takes is a willingness to challenge an existing practice with a better idea and the persistence to convince an industry to listen.” Hospital officials say they're caught between two extremes. While contract auditors push them to use patient observation more often instead of inpatient admissions, HHS' inspector general's office announced in its annual workplan for 2013 that it is investigating the effects of observation on patients, including how “improper” use of inpatient status subjects Medicare beneficiaries to high cost-sharing.The American Hospital Association has encouraged members to use thorough documentation as a way to reduce their vulnerability to payment denials by Medicare RACs. Earlier this year, the AHA hosted a webcast session for hospitals featuring speakers from Milliman discussing “proactive steps” hospitals can take to reduce audit vulnerabilities.But AHA officials say criteria-screening systems are not a panacea. Only proper documentation by clinical staff can prove the efficacy of a decision to admit an inpatient.Dr. David Ficklen, chief medical officer at Huntsville (Texas) Memorial Hospital, says emergency department physicians also feel caught in the middle.They know that Medicare auditors and hospital utilization review committees could challenge their decisions to admit patients for acute care, but they also know that hospitals would rather have the higher revenue from an inpatient admission. On top of that, the criteria for admitting inpatients are evolving, and “diseases that we used to slam-dunk admit 100% of the time are no longer always admitted,” Ficklen says.Given those competing forces, he sees emergency physicians as not hostile toward the systems because they help bring clarity to decisions that may be counter-intuitive. Even in cases where a physician disagrees with an admission-criteria system's recommendation, that could just be signal that there's a problem with the documentation, rather than a challenge to the doctor's judgment and wisdom.“There are those times when the physician feels like there is more going on than observation, and the guidelines say observation,” Ficklen says. “It prompts them to do a little bit better documentation at that point.”TAKEAWAY: Admission-criteria software, along with government-contracted auditors, could be playing bigger roles in patient-care decisionmaking. On May 1, 2021, UnitedHealthcare (UHC) will transition its utilization management approach for all its health plans from Milliman Care Guidelines (MCG) to InterQual® criteria.That means, going forward, every hospital contracted with UHC without access to InterQual will need to determine how to evaluate admission status and medical necessity for services. A Closer Look: Definition And UseLet’s first address the purpose of InterQual and MCG. Healthcare providers and payers use these guidelines to assist in medical necessity determinations for appropriate level of care and admission status (inpatient vs. observation), inpatient length of stay, and medical necessity for outpatient services, such as diagnostic tests and surgeries.Both products are evidence-based clinical criteria, and both products assist in determining whether it is medically necessary for a patient to be admitted to the hospital. Medical Necessity for Inpatient level of care is based on two factors: Severity of Illness and Intensity of Service.Severity of Illness, as it implies, addresses the severity of a patient’s condition. Factors affecting this determination include abnormal lab or test results, abnormal physical assessment findings risk factors, comorbid conditions, and risk of mortality. Intensity of Service addresses the treatment plan. Treatments to support Inpatient level of care are those treatments that cannot be performed safely in an outpatient or home setting. Treatments such as intravenous (IV) medications (IV antibiotics), IV pain meds, or other medication to control symptoms), frequency of IV medications for symptom control, telemetry monitoring, close monitoring with special assessments (such as neurological assessments), monitoring for and/or treating side effects, etc. Inpatient treatments also include urgent surgeries and interventions that cannot be performed as an outpatient or at home. While both guidelines use Severity of Illness and Intensity of Service to reach a determination, the primary difference between the two approaches is the emphasis each set of guidelines places on the two factors. MCG focuses more on severity of illness and diagnosis. InterQual focuses more on intensity of service required and provides detailed day-by-day guidelines.Keep in mind, both MCG and InterQual provide “guidelines” only, and these guidelines do not substitute a physicians’ professional judgment and other factors when determining medical necessity. In addition, it is important to note that CMS (Centers for Medicare and Medicaid Services) does not endorse Interqual, MCG, or any other particular set of criteria.Your Questions, AnsweredNow what? At Advicare, we regularly hear questions from our hospital and health systems about this switch and what it might mean to their operations and their admission decision making, as well as whether or not they will see more or less clinical denials. Specifically, our clients most frequently ask the following questions:1. How will this change in criteria impact admissions for patients with UHC insurance if the hospital does not utilize InterQual?Whether a hospital uses InterQual or MCG, the change should have minimal impact. Remember, both criteria platforms only serve as guidelines. The key to preventing clinical denials on medical necessity grounds is documentation by the physician. Physician documentation needs to be objective and detailed, providing specific information to support both severity of illness and intensity of service. Moreover, the documentation should support the physician’s judgment and identify comorbidities as well as risk factors.2. What is the difference between the InterQual® criteria and MCG?As we described above, both guidelines evaluate severity of illness and intensity of service to help hospitals make an inpatient admission determination. However, MCG puts more emphasis on the patient’s severity of illness. And InterQual addresses both severity of illness and intensity of service, but it puts additional emphasis on the intensity of service required based on the patient’s condition.There is no definitive rationale as to why one group leans one way versus the other, but we do have our own observations about the two sets of criteria. In our opinion, the criteria set out in MCG is less precise, leaving room for interpretation. On the other hand, InterQual is very specific and detailed in setting criteria for both severity of illness (citing precise vital sign abnormalities, lab values, test results, etc.) and intensity of service (specific treatments/treatment plan that must be done) to meet inpatient level of care.Looking At The Bigger PictureRegardless of which criteria your hospital uses, there is no substitute for clear, complete, and timely clinical documentation. When the documentation reflects a true picture of the patient’s diagnosis, the patient’s care for that condition, and the quality of that care, it reduces ambiguity as to the level of care required for that particular patient.Are you interested in exploring how the transition to InterQual will affect your organization? To explore solutions and further examine your hospital’s approach to overturning clinical denials and denial prevention, contact us today.

what are the milliman care guidelines