InterQual & MCG

What Physician Advisors Need to Know (and What They Don't)
Physician Advisor Training – Reference Document

Why Physician Advisors Need to Understand IQ & MCG

Physician Advisors do not practice medicine through criteria tools. However, they practice in an environment where criteria tools influence utilization decisions.

InterQual (IQ) and MCG are embedded in Utilization Review workflows, Case Management processes, payer denial logic, and administrative expectations. A Physician Advisor who does not understand how these tools are used—and misused—will constantly be reacting instead of leading.

Understanding IQ and MCG is not about compliance. It is about context, positioning, and credibility.

What InterQual and MCG Actually Are

InterQual and MCG are commercially developed screening tools designed to support utilization review processes.

They provide standardized clinical pathways, assist non-physician reviewers, and promote consistency in utilization decisions. They function as decision-support frameworks, not clinical mandates.

They are proprietary, vary by version and payer, and are interpreted differently across organizations. Their value lies in screening and guidance—not authority.

What They Are Not

InterQual and MCG are not admission criteria, CMS regulations, determinants of medical necessity, substitutes for physician judgment, or binding standards of care.

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Meeting criteria does not automatically justify inpatient admission.
Failing to meet criteria does not automatically negate medical necessity.

Treating these tools as decisive authorities is a fundamental error—one that Physician Advisors must actively counter.

How Payers Use Criteria in Denials

Payers frequently reference InterQual or MCG in denial rationales, but their use is often selective and outcome driven.

Common behaviors include retrospective application of criteria, isolating individual elements rather than clinical context, substituting policy interpretation for clinical judgment, and using criteria to justify a pre-determined denial position.

Understanding this allows Physician Advisors to respond strategically rather than defensively.

InterQual, MCG, and CMS Medical Necessity

CMS does not define medical necessity through InterQual or MCG.

CMS standards are grounded in physician judgment, reasonable and necessary care, patient-specific risk and severity, anticipated clinical course, and required services.

Criteria tools may support documentation of risk or intensity, but they do not override CMS requirements or the Two-Midnight Rule.

Physician Advisors must anchor arguments in CMS standards first, with criteria serving only as supportive context when appropriate.

How Physician Advisors Should Position Criteria in Appeals and P2Ps

Effective Physician Advisors do not argue *from* criteria. They argue **through medicine**.

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Best practices include leading with clinical judgment and patient risk, framing criteria as supportive rather than determinative, redirecting conversations when criteria are treated as absolute, and emphasizing physician decision-making and anticipated need.

Criteria may inform discussion or highlight disconnects, but they should never replace the clinical narrative.

Common Pitfalls and Misconceptions

Physician Advisors should actively avoid:

- Treating criteria as admission checklists
- Allowing criteria to override clinical judgment
- Over-documenting to "meet criteria" instead of explaining necessity
- Conceding denials solely because criteria were not met
- Teaching physicians to practice to criteria rather than medicine

These pitfalls quietly erode the PA role and weaken institutional positioning.

Closing Perspective: Criteria as Input, Not Authority

InterQual and MCG are tools—not standards.

They can support review processes, provide structure for non-physician reviewers, and offer common reference points. They cannot replace physician judgment, define medical necessity, or override CMS requirements.

The Physician Advisor's role is not to comply with criteria—it is to contextualize them, subordinate them to medicine, and ensure they are used appropriately.

When criteria are treated as inputs rather than authority, they serve their purpose without distorting care.

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