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ABOUT AHCA

THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Florida Agency for Health Care Administration (AHCA or Agency) was statutorily created by Chapter 20, Florida Statutes. The Agency champions accessible, affordable, quality health care for all Floridians. It is the state's chief health policy and planning entity. AHCA is the single state agency responsible for administering Florida's Medicaid program which currently serves over 2.8 million Floridians. As such it develops and carries out policies related to the Medicaid program. The Medicaid program is administered by the Agency's Division of Medicaid Services.

AHCA'S MISSION

AHCA's mission is Better Health Care for All Floridians.

ABOUT eQHEALTH SOLUTIONS

COMPANY INFORMATION, MISSION, VISION AND VALUES

eQHealth Solutions is a non-profit, multi-state health care quality improvement, medical cost management and health information technology company providing a wide range of effective and efficient solutions for our clients. Services include care coordination, utilization review, quality improvement, wellness services and quality review for home and community based waiver services. eQHealth Solutions is a leader in assisting providers to embrace health information technology (HIT) to improve the quality of care provided to patients / recipients.

Corporate Mission

"Improve the quality and value of health care by using information and collaborative relationships to enable change"

Corporate Vision

"To be an effective leader in improving the quality and value of health care in diverse and global markets"

Corporate Values

- *Pursuit of innovation;*
- *Integrity in the work we do;*
- *Sharing the responsibility for achieving corporate goals;*
- *Treating people with respect;*
- *Delivering products and services that are valuable to customer;*
- *Fostering an environment of professional growth and fulfillment;*
- *Engaging in work that is socially relevant; and*
- *Continuous quality improvement*.

eQHEALTH SOLUTIONS LOCATIONS AND CLIENTS

Florida

eQHealth Solutions was awarded the contract in 2011 by Florida's Agency for Health Care Administration (AHCA or Agency) to serve as its Medicaid Quality Improvement Organization (QIO). On behalf of the Agency, our Florida location provides diverse medical cost and quality management services in a variety of inpatient and non-inpatient settings. Our main office is located in the Tampa Bay area.

Louisiana

Under a federal contract with the Center for Medicare and Medicaid Services (CMS) since 1986-2014, our office in Louisiana serves as the state's Medicare QIO. As the Louisiana QIO, eQHealth Solutions assisted providers in achieving significant improvements quality of care in areas such as heart attack and pneumonia care, nursing home quality, home care delivery, prevention and wellness and adoption of electronic health records. Starting in 2014 as a QIO- Like entity, we provide quality improvement field – based work as a subcontractor to a regional Medicare QIN-QIO.

In 2009, we began our Senior Medicare Patrol grant with the federal Administration for Community Living (formerly AoA) to develop and implement anti-fraud efforts in Louisiana with additional awards covering the sates of Florida and Mississippi. This work is supported through our QIO infrastructure.

Mississippi

Under contract with the State of Mississippi's Division of Medicaid (DOM) since 1997, eQHealth Solutions serves as the utilization management and QIO to provide health care quality and utilization management services in a variety of inpatient and non-inpatient settings. We also perform All Patient Refined-Diagnosis Related Group validation review.

Illinois

Under contract with the Illinois Department of Healthcare and Family Services (HFS), since 2002, eQHealth Solutions serves as the Medicaid QIO, providing acute inpatient quality of care and utilization management, DRG and APR-DRG validation review.

Colorado

Under Contract with The Colorado Department of Health Care Policy and Financing (HCPF), eQHealth Solutions provides services for the ColoradoPAR (prior authorization request) program, effective September 1, 2015. Together, eQHealth and HCPF will serve Medicaid members by focusing on and implementing HCPF's mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Vermont

Since June 2015, eQHealth has been contracted with the State of Vermont, Department of Health Access, as the utilization management and the care coordination software development vendor for a CMS advance planning document grant.

ACCESSIBILITY AND CONTACT INFORMATION

This section provides information about accessing the Comprehensive Medicaid Utilization Management Program (CMUMP) and provides important contact information.

SUBMITTING PRIOR AUTHORIZATION (REVIEW) REQUESTS

Methods of Submission for Care Coordination Recipients (Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Facilities (PPEC), Personal Care Services (PCS) in conjunction with PDN or PPEC.

All prior authorization (PA) review requests are submitted to eQHealth Solutions (eQHealth) via fax to the Care Coordination Fax Line 855-245-7418.

Review information and required documents are then uploaded to the eQCare Coordination System for entry into eQSuite once medical necessity is determined.

WHEN YOU NEED INFORMATION OR ASSISTANCE

AHCA and eQHealth are committed to delivering exceptional service to our customers. We offer a variety of ways for you to efficiently obtain the information or assistance you need. In the following sections we identify, by topic or type of assistance needed, useful resources.

For questions or information about the Comprehensive Medicaid Utilization Management Program, the following resources are available:

- Resources available on our Website: http://fl.eqhs.org:
  - This Provider Manual: Care Coordination Services Provider Manual
  - Training presentations: Copies of training and education presentations are available under the “Training/Education” tab.
- eQHealth Solutions customer service staff: Toll free number 855-444-3747.

eQHealth Solutions Customer Service

For general inquiries, inquiries that cannot be addressed through eQSuite, or if you have a complaint, contact our customer service staff.

The toll free customer service number is: 855-444-3747 (855-444-eqhs). Staff is available 8:00AM – 5:00PM Eastern Time, Monday through Friday, excluding the following State-observed holidays:

- New Year’s Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day
- Christmas Day
- Day After Thanksgiving

If you call during non-business hours, you will have the option of leaving a message. Calls received after business hours are answered by our customer staff the following business day.

If you have a complaint and would prefer to submit it in writing, send it to:

eQHealth Solutions, Inc.

Florida Division

Attention: Customer Service Department

5802 Benjamin Center Dr.

Suite #105

Tampa, FL 33634

SUBMITTING SUPPORTING DOCUMENTATION

It sometimes will be necessary to submit supporting information for authorization requests by Downloading the eQHealth Solutions fax cover sheet and faxing to the Care Coordination Fax Number 855-245-7418.

Requesting a Reconsideration of a Medical Necessity Denial

When eQHealth renders an adverse medical necessity determination for all or some of the requested services, the attending or treating physician, the hospital or the recipient may request reconsideration. Requests for reconsideration may be submitted:

Through eQSuite, or

- By:
  - Phone: toll free number 855-977-3747
  - Fax: toll free number 855-677-3747
  - U.S. mail, sent to:

  A reconsideration request form is posted on http://fl.eqhs.org, Home Health/PPEC tab, Forms and Downloads folder.

  eQHealth Solutions, Inc
  Florida Division
  5802 Benjamin Center Dr.
  Suite 105
  Tampa, FL 33634

QUICK REFERENCE: CONTACT INFORMATION

- eQHealth Solutions (eQHealth)
  - Submit a prior authorization request
    - By Fax toll free 855-245-7418
  - Submit additional information (24x7):

- Download the eQHealth cover sheet and fax the information to our toll free number 855-245-7418

♦ Submit a reconsideration review request by:

- Phone: 855-977-3747
- Fax: 855-677-3747
- U.S. mail, sent to:

  eQHealth Solutions, Inc
  Florida Division

  Attention: Customer Service Department
  5802 Benjamin Center Dr.
  Suite 105
  Tampa, FL 33634

♦ Obtain information about a previously submitted prior authorization request:

  eQSuite's provider review status reports or helpline module: available 24x7

♦ Customer service: 855-444-3747

- Speak with a customer service representative 8:00 AM – 5:00 PM Eastern Time, Monday through Friday except State-approved holidays.
- Leave a message 24x7.
- U.S. mail, sent to:

  eQHealth Solutions, Inc
  Florida Division

  Attention: Customer Service Department
  5802 Benjamin Center Dr.
  Suite 105
  Tampa, FL 33634

OVERVIEW: CARE COORDINATION

CARE COORDINATION PROGRAM COMPONENTS

Care Coordination is a model of care that makes the patient the central focus of each component of the health care network. As its name states, Care Coordination identifies all of the providers involved in the care of a patient, reaches out to each one and then includes them in all aspects of care for that patient. At the center of the Care Coordination model is the patient and a Care Coordinator.
The Care Coordinator is the day-to-day facilitator of a multidisciplinary team who assists the patient in navigating the health care system, sorting through medical data and assisting with social issues contributing to poor health outcomes.

eQHealth also has mechanisms in place for evaluating the quality, continuity, accessibility, timeliness and outcomes of services provided; this includes a process and quality improvement program designed to monitor Care Coordination efficiency and efficacy. Care Coordination programs are based on evidence-based nationally recognized standards of care that guide our interactions with participants and physicians to facilitate care and adherence to prescribed treatment plan.

REVIEW REQUIREMENTS

This section provides summary information about the following PDN/PCS Care Coordination program requirements:

- Services and codes subject to prior authorization
- Review request submission
- Supporting documentation
- Review request submission timeframes
- Review completion timeframes
- Reconsiderations
- Fair hearings

SERVICES AND CODES SUBJECT TO PRIOR AUTHORIZATION FOR PDN

Only certain PDN/PCS Common Procedure Coding Systems® (HCPCS) codes and modifiers are reimbursable by Medicaid. They are identified, by type of service, in the following tables.

Private Duty Nursing Codes	Modifier	Description of Service
S9123		Private duty nursing rendered by a RN (2 to 24 hours per day).
S9123	TT	Private duty nursing rendered by a RN (2 to 24 hours per day) provided to more than one recipient in the same setting.
S9123	UF	Private duty nursing rendered by a RN (2 to 24 hours per day) provided by more than one provider in the same setting.
S9124		Private duty nursing rendered by a LPN (2 to 24 hours per day).
S9124	TT	Private duty nursing rendered by a LPN (2 to 24 hours per day) provided to more than one recipient in the same setting.
S9124	UF	Private duty nursing rendered by a LPN (2-24 hours per day) provided by more than one provider in the same setting.

Codes Subject to PA for PPEC

Services to be billed under the following Healthcare Common Procedure Coding System (HCPCS) codes are subject to prior authorization	Code Description
T1025	Full-Day PPEC Services (over four hours, up to twelve hours per day)
T1026	Partial-Day PPEC Services four hours or less per day billed in units of one hour (A minimum of 15 minutes of service is required to round up to a full hour.)

Personal Care Services(PCS)	Modifier	Description of Service
S9122		Personal care rendered by a home health service provider (1 to 24 hours per day).
S9122	TT	Personal care rendered by a home health service provider (1 to 24 hours per day), provided to more than one recipient in the same setting.
S9122	UF	Personal care rendered by a home health service provider (1 to 24 hours per day), provided by more than one provider in the same setting.

All prior authorization (PA or review) requests are submitted to eQHealth Solutions via fax or phone from the provider, the parent/legal guardian, ordering physician or hospital discharge staff.

SUPPORTING DOCUMENTATION

Documentation Substantiating Service Necessity

Documentation substantiating the need for services is submitted with the review request.

Required Documentation

For information about what supporting documentation is required for what types of providers and services, go to our Web site: http://fl.eqhs.org. The information is located under "Home Health/PPEC", Forms and Downloads. Home health agencies: See the resource titled, "Home Health Services Required Supporting Documentation".

Unlicensed independent or group personal care providers: See the resource titled, "Unlicensed Independent Personal Care Services Required Supporting Documentation".

These essential resources provide detailed information about what documentation is required, for which service it is required and when it is required.

Forms

For some documentation a particular form is required. For others there may be a choice of forms. The forms that must or may be used are specified in the resources cited in the preceding section, "Required Documentation". For some documentation requirements AHCA has developed special forms that may be used. They may be downloaded from our Web site: http://fl.eqhs.org. Go to Home Health/PPEC: Forms and Downloads.

How to Submit Documentation

Documentation must be submitted via fax for PDN, PDN and PCS services provided by a Home Health provider. PCS only documentation must be submitted via eQSuite.

REVIEW REQUEST SUBMISSION TIMEFRAMES

There are five types of reviews. For each there is a required timeframe for submitting the request.

- Admission review (initial authorization)
- Prior authorization is required
- Continued stay (reauthorization) review
- Prior authorization is required.
- Modification review (if there is a change in the recipient's clinical status)

Authorization is required if, during an active approval period, a change in the recipient's clinical condition creates a need for an increase or other change in the previously approved services.

- Retrospective review

Performed when Medicaid eligibility is retroactively determined and the recipient is discharged from services.

Submit the request as soon as eligibility is confirmed. Claims must be submitted within one year of the eligibility determination. If eligibility is determined while services still are in progress, submit an admission review request.

- Reconsideration review

Performed after an adverse determination

Submit the request within 5 business days of the date of the denial notification.

REVIEW COMPLETION TIMEFRAMES

Reviews are completed within particular timeframes. The timeframe depends on the type of service and review. It also depends on whether the recipient is in Care Coordination. Lastly, the timeframe may depend on whether the request must be reviewed a physician.

Private duty nursing and personal care services Request	Submission	Response
Initial request for services	Prior to the initiation of services	Care Coordinator will make initial phone call attempt to the family and send a welcome letter within 5 days of the initial request for PDN services.
Initial request for services for a recipient being discharged from inpatient care	Upon initiation of discharge planning (prior to discharge)	The Care Coordinator will work with the hospital discharge planner prior to recipient leaving the hospital.
Request for Continued Services	Initiated by the Care Coordinator up to 30 days prior to the end of the current approval	Care Coordinator will schedule a multidisciplinary team meeting 30 - 45 days prior to expiration of the current authorization period.
Modifications	As soon as the need is identified	Care Coordinator will contact the parent to identify the need and follow up within 5 days of receipt of the request.

RECONSIDERATIONS:

If a second level review results in an adverse determination, that is, a denial in full or part of the services requested, a reconsideration request may be submitted

PDN, PDN AND PCS

A reconsideration request may be submitted by the recipient, parent/legal guardian, ordering physician or hospital discharge planner.

The request is submitted by fax, phone or mail.

PCS Only

A reconsideration request may be submitted by the provider, recipient, parent/legal guardian, ordering provider, discharge planner.

Providers can submit the request via eQSuite.

Providers, recipients, parents/legal guardians, ordering physicians and discharge planners may submit the request by phone, fax or mail.

Reconsideration requests must be submitted within five (5) days of the adverse determination notification, or the right to reconsideration is waived.

SUBMITTING PA REQUESTS AND SUPPORTING DOCUMENTATION

SUBMITTING PRIOR AUTHORIZATION REQUESTS

PDN, PDN/PCS referral requests are submitted by the provider, the recipient, the recipient's parent/legal guardian, the ordering provider or the hospital discharge planner either via fax or phone. PCS only service review requests are submitted via eQSuite.

Submitting Supporting Documentation

Certain supporting documentation is needed with PDN, PDN/PCS referral requests
Documentation for review requests submitted via eQSuite may be submitted by faxing to accessible toll-free fax number: 855-245-7418

FIRST AND SECOND LEVELS OF REVIEW

eQHealth Solutions provides two levels of review. They are distinguished by their:

- Clinical credentials;
- Determinations they may render and how they render those determinations.

With the exception of reconsideration reviews, all PDN, PDN and PCS review requests are processed by Care Coordinators after consultation with the family, a recipient assessment and a multidisciplinary team meeting.
PCS only review requests are reviewed by first level clinical reviewers.
Reconsideration requests are addressed by physician reviewers.

FIRST LEVEL REVIEW

First Level Reviewer and Care Coordinator Credentials

Our 1st level reviewers are Florida licensed registered nurses who have at least two years home health experience.
Our Care Coordinators are Florida licensed nurses (RNs or LPNs) or social workers (at least Masters' prepared) who have at least two years home health experience.

First Level Review Determinations

After consultation with the recipient or recipient's parent/legal guardian and an assessment of the recipient, and a multidisciplinary team meeting, as indicated, Care Coordinators may render one of the following review determinations:

- **Approve the medical necessity of the services as requested.** The determination includes approval of a particular number and frequency of units and the duration of the service.
- **Refer the request to a physician reviewer.** This determination is rendered when:
  - The criteria, guidelines and/or length of stay (LOS) policies are not satisfied;

  - During a face-to-face recipient visit, and/or multidisciplinary team meeting consensus regarding the appropriate services cannot be reached.

- **Technical denial of the request:** This non-clinical determination is rendered when there is non-compliance or inconsistency with an eligibility requirement or with any Agency administrative policy or rule.

Clinical reviewers and Care Coordinators may not render an adverse determination. When the clinical reviewer or Care Coordinator is not able to approve the services on the basis of the complete information provided, (s)he must refer the request to a second level (physician peer) reviewer.

First Level Review Clinical Decision Support Tools

When performing a review, the results of the recipient assessment, family input and the multidisciplinary team meeting, as well as Agency-approved clinical criteria, guidelines and policies to substantiate the medical necessity of the services, are applied. The applicable decision support tools depend on the type of services for which authorization is requested. If a request for PCS only services cannot be approved, the family is contacted by a Care Coordinator.

If consensus regarding the services needed is reached, the services are authorized.

If consensus regarding the services needed is not reached, the case is referred to a second level Peer Reviewer.

SECOND LEVEL REVIEW

Second Level Reviewer Credentials

Second level (physician peer) reviewers are:

- Florida-licensed physicians of medicine, osteopathy or dentistry, located in Florida and in active practice;
- Are board certified in the specialty for the service they are asked to review. For PDN services, the physician reviewer (PR) is board certified in pediatrics and has at least five years recent experience in pediatric care;
- Are on staff at or have active admitting privileges in at least one Florida hospital.

Physician reviewers may not review any request for which a known or potential conflict of interest exists.

Physician Reviewer Role
Physician peer reviewers review all:

- Authorization requests that cannot be approved by a 1st level reviewer or Care Coordinator.
- Requests for reconsideration of an adverse determination.

The review is performed by a PR who is of the same or similar specialty as the ordering physician.

Second Level Review Determinations
A PR may render one of the following determinations:

- Approval of the services as requested;
- Pend the request for additional or clarifying information from the ordering physician;
- Denial: All services are found not to be medically necessary;
- Partial denial: This determination is a finding that some of the services, the frequency and/or duration of services are not medically necessary. The result is a reduction in approved services.

When a request for a reconsideration of an adverse determination is submitted, the reviewing physician renders one of the following determinations:

- Uphold the original adverse determination;
- Modify the original determination, approving a portion of the services;
- Reverse the original determination, approving the services as originally requested.

PDN/PCS SERVICES PRIOR AUTHORIZATION PROCESS

In this section we explain the prior authorization (review) process for PDN/PCS service referrals. The type of service and/or authorization process may influence:

- Administrative requirements
- Supporting documentation requirements
- Whether care coordination is implemented
- Whether a family telephone call, face-to-face to recipient visit or multidisciplinary team meeting is required prior to rendering a medical necessity determination
- The maximum service approval period

In the following sections we explain the review process for:

- Initial Referral
- Continued stay requests
- Modification review requests
- Retrospective review requests

Any service-specific process differences are noted. Since there are several process differences for reconsideration requests, the reconsideration review process is discussed separately.

SERVICE REFERRALS

When a referral for PDN or PCS services is received, each service for which authorization is requested must be itemized. For example, if authorization is requested for both PDN and PCS by a Home Health provider, separate codes must be documented for each service. For each service to be provided, the number of service units, the frequency, and the duration must be provided. A determination is rendered for each service requested.

ADMINISTRATIVE SCREENING

When the request is received, the request is reviewed to ensure that review is required and that all eligibility, coverage and administrative requirements are satisfied. When there is a failed administrative requirement, the review request is cancelled and all involved parties are notified.

Care Coordination

When PDN or PDN and PCS are requested by a Home Health provider, a hospital discharge planner, an ordering provider or a recipient or recipient's parent/legal guardian, the case is assigned to a Care Coordinator who will:

- Enter the request in eQSuite and the Care Coordination module;
- Contact the family telephonically;
- Complete a recipient assessment;
- Schedule a multidisciplinary team meeting, if indicated, and assist in obtaining and review the supporting documentation.

Pending Review Requests

Screening for Complete Clinical Information

Authorization cannot be granted until all the required supporting documentation is received and reviewed to ensure that it is legible and conforms to the AHCA requirements.

Pended and Suspended Review Requests

When the Care Coordinator *pends* a review request supporting documentation from the provider or the ordering physician:

- The provider or ordering physician is notified;
- The requested information must be submitted within one business day.

If eQHealth does not receive the information within one business day of the notification, the review request is *suspended* and no further review processing occurs.

- The provider is notified through the system status report that the request is suspended.
- If the information is submitted at a later date, eQHealth re-opens the request and reviews those services beginning from the date the complete information was received.

Approvals

In combination with the recipient assessment, face to face visit and multidisciplinary team meeting, Care Coordinators apply criteria to determine whether services are medically necessary or are otherwise allowable and the duration of the services as permitted by policy. In no event will the number, frequency and duration approved exceed that ordered by the physician, requested by the provider or permitted by policy. The maximum service duration a Care Coordinator may approve for medically necessary services is shown below:
Personal care (PC) services: The maximum service duration depends on whether the parent or caregiver is attending school.

- If the parent or caregiver attends school: To the date of the end of the school term or through 180 calendar days (continued stay), whichever is less.
- If the parent or caregiver is not attending school: 180 calendar days.
- Private duty nursing services
- Initial referral: 180 days
- Subsequent requests (continued stays): 180 calendar days.

Approval Notifications

When all criteria and service duration policies are satisfied and consensus with the family is reached, the Care Coordinator approves the services and approval notifications are generated.

Provider Notifications

Electronic notifications are posted for providers in eQSuite. For PCS Providers, when the determination is rendered, eQSuite immediately generates an email notification to the provider who requested the review. The email advises the provider to log in to eQSuite and check the secure web-based provider review status report. The provider then may access the report to see the determination.

Within one business day of the determination, we electronically post a written determination notification. Providers may access the notification by using their eQSuite secure log on. The notifications can be downloaded and printed.

- The approval information is transmitted to the Medicaid fiscal agent.
- The fiscal agent transmits the prior authorization (PA) number to eQHealth.
- Within 24 hours of our receipt of the PA number, we update the provider's review status report to include the PA number.
- The approval information includes the last date certified.
- Recipient notifications: The recipient (or legal representative) receives a written notification. It is mailed within one business day of the determination.

Referral to a Physician Reviewer

First level reviewers and Care Coordinators may not render an adverse determination. They refer to a physician peer reviewer any authorization request they cannot approve. This includes requests when criteria are not satisfied and when the requested service duration exceeds that which may be approved by a Care Coordinator, or consensus with the family cannot be reached.

Second Level (Physician Peer) Review Process

Process Overview

When we schedule physician reviews, every effort is made to match the care being reviewed to a physician of the same specialty. Physicians who review PDN are board certified in pediatrics and have at least five years recent experience in pediatric care.

The PR uses his/her clinical experience and judgment and considers all of the following factors:

- As applicable for the patient and for the services under review, whether the services for which authorization is requested are eligible for reimbursement.
- Whether the services for which authorization is requested conform to the Agency's definition of medical necessity;
- As applicable for the patient and for the services under review, consistency with other applicable Agency definitions such as the definition of medically complex.

The patient's:

- Current clinical condition, diagnosis and prognosis;
- Treatment plan and whether it is adequate and appropriately customized to meet the patient's unique needs;
- Progress toward meeting treatment plan goals and whether the maximum medical benefit has been achieved;

Given the patient's clinical status, whether there is an available and appropriate less intensive, less restrictive or more conservative care option;

- Generally accepted professional standards of care; and
- Recipient and parent/legal guardian input.

The PR may approve (authorize) the services on the basis of the information provided. Or the PR may determine additional information is needed and pend a review request while attempting to obtain the information from the attending or ordering physician.

- *Approval on the basis of available information*: When the available information substantiates the medical necessity of the services, the number of service units and the frequency and duration of services, the PR approves the services as requested and the review is completed. Notifications are issued.
- *When additional information is required*: If the PR is not able to approve the services on the basis of the available information, (s)he attempts to speak with the attending or ordering physician to obtain additional or clarifying information. PRs do not render adverse determinations without first attempting to speak with the physician.
- *PR pended review requests*: If the ordering physician is not available when our physician calls, the PR may issue a pend determination at that time. The particular information required is documented in the review record.

The information must be provided within one business day. If the requested information is not received within one business day, the PR renders a determination on the basis of the information that is available.

Adverse Determinations

Only a PR may render an adverse determination. As noted in the preceding section, prior to rendering an adverse determination our PR will attempt to have a peer-to-peer discussion with the ordering physician.
There are two types of adverse determinations: denial and partial denial.

Denial

The physician reviewer may render a (full) medical necessity denial of one or more service line item(s). The requesting provider receives immediate electronic notification, via email and the eQSuite review status report, of the denial, if it is a PCS review/provider.

Within one business day of the determination, a written notification of the denial is posted electronically for the provider. The notice may be downloaded and printed. Written notifications are faxed or mailed to the ordering physician and to the recipient or the recipient's legal representative.

Given the patient's clinical status, whether there is an available and appropriate less intensive, less restrictive or more conservative care option;

- Generally accepted professional standards of care; and
- Recipient and parent/legal guardian input.

Partial Denial (Service Modification or Reduction in Services)
The physician also may render a partial denial for one or more services. When a partial denial is rendered, some of the services are approved and some are denied. Therefore there is a reduction in the services for which authorization was requested, but there is not a full denial of the services. This adverse determination may involve a denial of the number of units requested, the frequency and/or the duration of the service(s).
For partial denials:

- Notifications are issued to all parties as described in the preceding section, "Denial".
- The approval information is transmitted to the fiscal agent. The provider's eQSuite status report is updated with the PA number as previously described for approval determinations.

RECONSIDERATION REVIEWS

Any party may request a reconsideration of an adverse determination of PCS services Recipients, parents/legal guardians, ordering physicians and hospital discharge planners my request a reconsideration of an adverse determination of PDN, PDN and PCS services.
The written notification of the adverse determination includes information about the right to request reconsideration. It also includes information about how to request reconsideration review.

- The reconsideration request must be received within five (5) business days of the date of the adverse determination notification.
- Home Health and unlicensed PCS providers request reconsideration through eQSuite. Providers, for PCS services.
- Physicians, recipients, parents/legal guardians, ordering physicians and discharge planners may submit reconsideration requests by fax, phone or mail.
- Requests for reconsideration for recipients in Care Coordination are submitted to the Care Coordinator by the recipient, parent/legal guardian, ordering provider or discharge planner.
- The requesting party should submit additional or clarifying information.

Administrative Screening of Reconsideration Requests

When a reconsideration request is received it is screened to ensure it complies with administrative requirements. It must be received within the required timeframe and must be

submitted by a party who is entitled to request a reconsideration. When the request does not conform to administrative requirements:

- The request is denied.

- The provider is notified electronically or (for a physician and recipient) in writing that the request is denied.

Processing Valid Reconsideration Requests

Only a physician peer reviewer may conduct a reconsideration review. When a valid reconsideration request is received:

- Any additional information submitted by fax is linked to the review record. Information submitted by phone is documented in eQSuite;
- The review is scheduled for a peer-matched physician reviewer who was not involved in the original determination.

Conducting the Review

The physician peer reviewer evaluates all available information including previous information and all additional information submitted. The review is performed according to the process described for all second level reviews.

Types of Determinations and Determination Implications

A determination is rendered for each service line item for which a reconsideration is requested. When reconsideration is requested for multiple services, there may be a different determination for each. The determination may be one of the following:

- **Modify**: Some of the services are approved and some continue to be denied.
- **Reverse**: The services are approved as originally requested. The original adverse determination is over-turned.
- **Uphold:** The original denial is maintained.

When the reconsideration determination results in a modification or reversal of the original determination:

- The determination and notification will specify the approved number of units, the frequency and the duration. The approved “through date” serves as the provider’s trigger to submit a reauthorization request when PCS services are planned beyond that date.

- The approval information is transmitted to the fiscal agent. The provider’s review status report is updated with the PA number within 24 hours of eQHealth’s receipt of the number when a PA was not previously issued.

The reconsideration determination is final. When the determination is to modify or uphold the original adverse determination, no further reconsideration is available. However the recipient may request a fair hearing.

Completion Timeframe and Notifications
Reconsideration reviews are completed within three business days of our receipt of a complete and valid request. Notifications are issued to all parties by the methods and within the timeframes described for all second level review determinations.

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