# TABLE OF CONTENTS

About AHCA and Florida Medicaid ..... 2
About eQHealth Solutions ..... 6
Accessibility and Contact Information ..... 4
Overview: Home Health Services Utilization Management ..... 8
Submitting PA Requests and Supporting Documentation ..... 11
First and Second Levels of Review ..... 13
Home Health Services Prior Authorization ..... 15
Fraud and Abuse Reporting ..... 23
This Page Intentionally Left Blank ..... 24

# 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.

## 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. At the end of this section we provide a quick reference guide of web site links and toll free telephone and facsimile (fax) numbers.

## SUBMITTING PRIOR AUTHORIZATION (REVIEW) REQUESTS

### Methods of Submission

All prior authorization (PA) review requests are submitted to eQHealth Solutions (eQHealth) through our proprietary, HIPAA-compliant web-based system, eQSuite, at http://fl.eqhs.org.

> The only exception is for physicians who do not have access to eQSuite and who are submitting PA requests for scheduled elective inpatient procedures. Physicians without access to eQSuite may submit review requests by fax to 855-440-3747. The applicable forms, available on our website http://fleqhs.org, must be used.

Both methods of request submission are available 24 hours a day, seven days a week.

## 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:
  - Codes for Home Health services are listed under the Home Health tab.
  - This Provider Manual: Home Health 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.

### Questions about Submitting PA Requests or about Using eQSuite

- *eQSuite User Guide for eQReview for Home Health Services* available on our website: http://fl.eqhs.org

### Checking the Status of a PA Request or Submitting an Inquiry about a Request

- Check the status of a previously submitted PA request: Use your secure eQSuite login and check the information in your review status report.
- Submit an inquiry using eQSuite's helpline module. You may use it when you have a question about a previously submitted PA request.

Both options are available 24 hours a day. Although using eQSuite is the most efficient way to obtain information about PA requests, you also may contact our customer service unit.

### 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

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. We provide two methods for submitting supporting documentation. You may:

- Upload and directly link the information to the eQSuite review record, or
- Download eQHealth's fax cover sheet(s) and fax the information to our toll free fax number: 855-427-3747.

## 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, Inpatient 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

- Web site (24x7): http://fl.eqhs.org
- By fax (only for physicians without eQSuite access): toll free 855-440-3747
  - Submit additional information (24x7):
- Upload and directly link the information to the eQSuite record, or
- Download the eQHealth cover sheet and fax the information to our toll free number 855-427-3747

- Submit a reconsideration review request by:

- Web: http://fl.eqhs.org
- 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: HOME HEALTH SERVICES UTILIZATION MANAGEMENT

## SERVICES AND CODES SUBJECT TO PRIOR AUTHORIZATION - FOR RECIPIENTS RECEIVING SKILLED AND UNSKILLED HOME HEALTH VISITS.

## (REFER TO THE "CARE COORDINATION SERVICES PROVIDER MANUAL FOR RECIPIENTS UNDER AGE 21 RECEIVING PDN/PCS SERVICES)

Only certain Healthcare Common Procedure Coding Systems® (HCPCS) codes and modifiers are subject to review by eQHealth. They are identified, by type of service, in the following tables.

**Home Health Visit Codes**

| Code | Modifier | Modifier | Description |
|---|---|---|---|
| T1030 | | | RN visit. |
| T1030 | GY | | RN visit to dually-eligible recipient. |
| T1031 | | | LPN visits. |
| T1031 | GY | | LPN visits to dually-eligible recipient. |
| T1021 | TD | | Home health aide (HHA) visit-associated with skilled nursing services. |
| T1021 | TD | GY | Home health aide (HHA) visit-associated with skilled nursing services to dually-eligible recipient. |
| T1021 | | | Home health aide (HHA) visit-unassociated with skilled nursing services. |
| T1021 | GY | | Home health aide (HHA) visit-unassociated with skilled nursing services to dually-eligible recipient. |

**Personal Care Service Codes**

| Code | 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. |

## REVIEW REQUEST SUBMISSION

All prior Home Health and PCS authorization (PA or review) requests are submitted

electronically using eQSuite. You may download the eQSuite *User Guide for Home Health Services* from our web site: http://fl.eqhs.org.

## SUPPORTING DOCUMENTATION

### Documentation Substantiating Service Necessity

Documentation substantiating the need for services must be 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. Documentation requirements may differ for home health agencies and for unlicensed independent or group personal care services provider.

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 home health services 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.

## REVIEW REQUEST SUBMISSION TIMEFRAMES

There are six types of review requests. For each there is a required timeframe for submitting the request.

#### Admission review (Initial authorization)

If it is not possible to obtain all required supporting documentation for recipients pending hospital inpatient discharge, submit the request within five business days of initiating services.

#### Continued Stay Review(Reauthorization)

Submit the request up to 14 calendar days before the end of the current approval period.

#### 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.

Submit the request as soon as the need is identified, and

- the additional services are ordered by the physician, and
- a revised plan of care (POC) is developed.

### Reconsideration review

Performed after an adverse determination if the physician, home health (HH) services provider and/or recipient/legal guardian requests review by another physician.

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 HH service and review. The timeframe may also depend on whether the request must be reviewed by a physician. The review completion timeframe is measured from the date we receive all required information.

### Home health visits (skilled nursing and aide visits)

Admission, continued stay and modification

- When the services can be approved by a nurse: Within one business day.
- When physician review is required: Within two business days.

Reconsideration review: Within three business days of the reconsideration request.

### Personal care services

Admission, continued stay and modification requests:

- When the services can be approved by a nurse: Within one business day
- When physician review is required: Within three business days.
- Additional time may be required if the recipient is in the Care Coordination program.

Reconsideration review: Within three business days of the reconsideration request.

# SUBMITTING PRIOR AUTHORIZATION REQUESTS AND SUPPORTING DOCUMENTATION

## SUBMITTING PRIOR AUTHORIZATION REQUESTS

Hospitals submit all authorization requests using our proprietary web-based prior authorization system, eQSuite. Physicians who have access to eQSuite also use eQSuite to submit prior authorization requests for scheduled elective admissions for surgical procedures.

Physicians without access to eQSuite submit elective procedure PA requests by fax. eQHealth's procedure-specific fax forms must be used. They are available on our website http://fleqhs.org. Our toll-free fax number is 1-855-440-3747.

### eQSuite

#### *Key System Features*

Among eQSuite's many features are:

- Secure HIPAA-compliant technology allowing providers to electronically record and transmit most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users.
- 24x7 access with easy to follow data entry screens.
- Rules-driven functionality and system edits which assist providers by immediately alerting them to such things as situations for which review is not required.
- A reporting module that provides the real time status of all review requests.
- A helpline module through which providers may submit questions about a particular PA request.

**Minimal Computer System Requirements**

- Any of the two most recent versions of:
- Internet Explorer, Google Chrome, Mozilla Firefox, Safari using a Broadband internet connection.
- Minimum System Requirements

Each provider designates a user or system administrator. eQHealth assigns a user ID and password for him or her. The administrator, who need not have any information systems technical background, will have access rights to create, terminate and maintain user IDs and passwords for each user in

your facility or, as applicable, physician office. Managing system access is a user-friendly, non-technical process.

## SUBMITTING SUPPORTING DOCUMENTATION

Sometimes it will be necessary to provide supporting documentation with authorization requests. We offer two methods of submitting the documentation: You may:

- Upload and directly link the information to the eQSuite review record, or
- Download from our Website, http://fl.eqhs.org, the appropriate eQHealth fax cover sheet(s). You then complete the information and fax it toll-free to 1-855-440-3747.

If you choose to fax the information you must use eQHealth's special fax cover sheets. Each cover sheet includes a bar code that is specific to the particular recipient and for the type of required information. The bar code enables automatically linking of the information to the correct recipient review record. Use of the bar coded cover sheet:

- Assures the image is linked to the correct review record.
- Provides an effective audit trail for ensuring that all required documentation submitted is complete and timely.

# FIRST AND SECOND LEVELS OF REVIEW

eQHealth Solutions provides two levels of review. They are distinguished by their: Clinical credentials and Determinations they may render and how they render those determinations.

With the exception of reconsideration reviews, all home health (HH) service review requests are processed by 1st level reviewers (clinical or nurse reviewers). Reconsideration requests are reviewed by the Recon nurse reviewer and then addressed by physician reviewers.

## FIRST LEVEL REVIEW

### First Level Reviewer Credentials

Our 1st level reviewers are Florida licensed registered nurses who have at least two years home health experience. Clinical reviewers who review home health care and personal care services (PCS) authorization requests also have at least two years pediatric care experience.

### First Level Review Determinations

First level reviewers 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.
- Pend the request for additional or clarifying information from the provider.
- Refer the request to a physician reviewer. This determination is rendered when:
  - The clinical reviewer's criteria, guidelines and/or length of stay (LOS) policies are not satisfied.
  - Clinical reviewers may not render an adverse determination. When the clinical reviewer 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.

## 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.
- Board certified in the specialty for the service they are asked to review.
- 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.
- 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

- For general reviews, 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.

# HOME HEALTH SERVICES
# PRIOR AUTHORIZATION PROCESS

In this section we explain the prior authorization (review) process for home health services. The type of service and/or authorization request may influence:

- Administrative requirements.
- Supporting documentation requirements.
- Whether care coordination is implemented.
- The maximum service approval period.

In the following sections we explain the review process for:

- Admission review requests.
- Continued stay requests.
- Modification review requests.
- Retrospective review requests.

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

### HOME HEALTH SERVICES LINE ITEMS

When providers submit authorization requests for skilled nursing and/or aide services, each home health (HH) service, for which authorization is requested, must be itemized. That is, each service code must be entered in eQSuite as a separate line item. For example, if authorization is requested for both skilled nursing and aide services, a separate line item is required for each. 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 line item.

## AUTOMATED ADMINISTRATIVE SCREENING

When the review request is entered in eQSuite the system applies a series of edits to ensure review is required and that all eligibility, coverage and administrative requirements are satisfied. When there is a failed administrative requirement, the system prohibits further review processing.

## NURSE REVIEWER ADMINISTRATIVE SCREENING OF THE ENTIRE REQUEST

When no exclusions are encountered by eQSuite, the system routes the request for first level screening and review. The nurse reviewer evaluates the entire request for compliance with any Medicaid policies or other administrative requirements that cannot be applied by eQSuite and for compliance with supporting documentation requirements.

### Administrative Requirements Screening

When the nurse reviewer identifies an administrative issue/policy breach, the request is cancelled. The requesting provider is notified electronically through eQSuite. The reason for the cancellation is specified. Since a cancelled review is rendered for an administrative reason, not a clinical or medical necessity reason, it is not subject to reconsideration.

The recipient is notified in writing of the cancellation and may request a fair hearing.

### Supporting Documentation Screening

Required supporting documentation must be submitted with the authorization request, must be clear, legible and current and must comply with all AHCA policies. These include the type of documentation required and the documentation content.

If all required supporting documentation is not received with the request, the nurse reviewer pends the request. The provider is notified electronically that the information must be received within one business day. If it is not, the review request is suspended and the requesting provider is notified electronically. If the information is submitted at a later date eQHealth will re-open the review and review will be performed for services beginning from the date the information was received.

## NURSE REVIEWER LINE ITEM SCREENING

### Administrative Screening

When there are no issues requiring a cancellation of the entire authorization request, the clinical reviewer performs an administrative screening of each individual service line item. The nurse reviewer evaluates each line item to ensure:

- Each service is eligible for coverage and no review exclusion exists.
- The supporting documentation requirements applicable to each service are satisfied.
- If a review exclusion exists or an administrative requirement or policy is not satisfied for a particular line item, the first level reviewer issues a technical denial for that service line item. The provider is notified electronically through the system status report that a technical denial has been rendered. The particular service/line item for which the technical denial is rendered is specified. A technical denial, rendered for an administrative reason, is not subject to reconsideration.

## Screening Clinical Information and Pending Review Requests

### *Screening for Complete Clinical Information*

The nurse reviewer screens the submitted clinical information to ensure it is sufficient to complete the medical necessity review. When additional clinical information is required or when the available information requires clarification, the first level reviewer pends the review request and specifies the information or clarification needed.

### *Pended and Suspended Review Requests*

When the nurse reviewer *pends* a review request:

- An advisory email is generated to the requesting provider. The provider accesses the review record to determine what additional information is needed.
- 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.

## Screening for High Risk or High Use Recipients

Our data management system maintains a comprehensive history of all services previously authorized for a recipient. Regardless of the type of home health service, the prior authorization process includes screening historical and current information to identify recipients who may be at risk for high or inappropriate utilization. First level reviewers may request from the provider additional or clarifying information when a recipient is identified as being potentially high risk. They also may consult with a physician reviewer before proceeding with medical necessity review.

## NURSE REVIEWER ACTIONS FOLLOWING THE CLINICAL SCREENING

Except for services for which a technical denial was issued, when all information has been submitted and the clinical information screening is completed, the nurse reviewer proceeds to the next step. The action the nurse takes depends on the type of service for which authorization is requested.

**Home health visits** (skilled nursing or a combination of skilled nursing and HH aide visits):

Perform the medical necessity review.

On Admission Reviews Home health aide visits w*ithout skilled nursing services*:  Refer to a PR.

**Personal care services**:

Perform the medical necessity review.

## FIRST LEVEL MEDICAL NECESSITY REVIEW PROCESS

When performing medical necessity review the first level reviewer evaluates all clinical information recorded in eQSuite and evaluates the information in the supporting documentation. The reviewer evaluates each service line item individually and renders a separate determination for each.

### Approvals

#### *Medical Necessity Approval*

First level reviewers apply criteria to determine whether services are medically necessary or are otherwise allowable.

#### *Service Duration Approval*

After the medical necessity of services has been substantiated through criteria satisfaction, the nurse reviewer determines the number of units of service, the frequency and the duration that may be approved. The maximum service duration approved by a nurse reviewer is a matter of policy and depends on the type of services. 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 first level reviewer may approve for medically necessary services is shown below:

- Home Health Visits:  60 calendar days for both admission and continued stay requests.
- Personal Care Services: 180 calendar days for both admissions and continued stay requests.

When all criteria and service duration policies are satisfied the nurse approves the services as proposed by the provider and approval notifications are generated.

Provider notifications:

- Electronic notifications are generated for 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.
- 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. This date serves as the trigger to submit a continued stay review request if the patient will not be discharged from HH services on or before the date following the last day 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 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 nurse. It also includes requests for services which, by policy, must be reviewed by a PR.

When the first level reviewer refers a review request to a physician reviewer the requesting provider receives notification of the referral. The notification methods and process are as explained in the preceding section for approvals.

## 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.

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.
- Are applicable for the patient and for the services under review and consistent 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.

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 as described under "First Level Medical Necessity Review Process: *Approval Notifications*".

*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 requesting provider receives an electronic notification of the pended review. The information must be provided within one business day.

## 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.

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.

The written notification includes information about the providers' and recipient's right to a reconsideration of the adverse determination.

### *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.

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 5 business days of the date of the adverse determination.

Home health services providers request reconsideration through eQSuite. Providers, physicians and recipients may submit reconsideration requests by fax, phone or mail.

The requesting party should submit additional or clarifying information.

Providers, physicians and recipients (or their legal representatives) may submit the additional information by fax or phone.

> *Home health services providers are strongly encouraged to serve as the coordination entity for the physician and recipient and to submit any additional information on behalf of all.*

## 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 requesting party 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 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.

### 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.

## FRAUD AND ABUSE REPORTING

eQHealth immediately notifies the Agency of any instance of potential fraud or abuse. The Agency provides direction in what, if any, alteration in the review process is required as a result of the reported incident.

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