ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Informational Notice

Date: February 5, 2014

To: Enrolled Hospitals: Chief Executive Officers, Chief Financial Officers, Patient Accounts Managers, and Health Information Management Directors; and Physicians

Re: Utilization Review – Prior Authorization Review for Coronary Artery Bypass Graft and Back Surgery Procedures

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As a result of *Public Act 097-0689(pdf)*, referred to as the Save Medicaid Access and Resources Together (SMART) Act, the department is implementing prior authorization review for **elective** coronary artery bypass graft (CABG) and back surgery procedures.

Effective with elective general inpatient admission dates beginning April 1, 2014, all ICD-9-CM procedures identified on new Attachment F will be subject to prior authorization review. The department's Quality Improvement Organization (QIO), eQHealth Solutions, Inc., will perform the review regardless of the hospital's reimbursement methodology. Concurrent review will **not** be performed. The QIO will only approve the procedure, not the length of stay. Hospitals enrolled as Long Term Acute Care (LTAC) hospitals are exempt from these review requirements, as all of their inpatient admissions require certification of admission and concurrent/continued stay review.

Outline of Prior Authorization Review Process for Procedures on Attachment F

- Effective with elective admission dates beginning April 1, 2014, the hospital is responsible for notifying the QIO a minimum of three business days up to a maximum of 30 calendar days prior to the planned procedure to request prior authorization review. **The prior authorization is a requirement for elective procedures.** The physician must provide to the hospital the specific medical information needed for the review. Hospitals are to submit prior authorization requests through the QIO's web-based system, eQSuite™. The QIO will provide training for hospitals.

- First level (nurse) reviewers will use InterQual® procedural criteria to screen for medical necessity of the procedure. The QIO will complete the review within two business days from receipt of all required documentation. The hospital, as well as the operating physician, will receive correspondence from the QIO detailing approval or denial. Hospitals must receive approval prior to performing the procedure. **Hospitals will not be reimbursed without an approved principal procedure on file.**

- If the request is approved, the approval is valid for a 60-day period from the date of the QIO's approval letter. If the surgery cannot be completed within the 60-day timeframe; the patient is admitted to another hospital; or the planned principal procedure code changes, the hospital must submit a request for prior authorization to the QIO for a new approval. If the planned admission date changes to a new date within the original 60-day authorization period, the hospital may update the admit date using an eQSuite™ utility.

- If the QIO receives an incomplete request, the hospital will be allowed one business day to forward additional information. The QIO will suspend the review while waiting for the additional documentation. If additional information is not received, the QIO will cancel the review, and the minimum three business-day timeframe must start again.

- If a request is denied, the hospital or the physician may request an expedited reconsideration. The QIO must receive the written request for reconsideration within 10 business days of the denial notice and prior to admission. The QIO will complete reconsideration review within three business days of receipt of a complete reconsideration request.

- If the procedure is denied, but the hospital performs the procedure and bills the claim, the department will deny the claim with error code G67 – Prior Authorization Req for Procedure by QIO.

- After an approved procedure has been performed, hospitals must identify the surgery as elective by using Type of Admission "3" on the institutional claim format. The UB-04 Data Specifications Manual defines an elective admission as one where the patient's condition permits adequate time to schedule the services.

Exceptions to Approval Process

As with other types of utilization review, certain exceptions to this approval process may apply, if:

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment occurred at the time of admission.
- Other – the hospital must provide narrative description.

Please contact a UB-04 Billing Consultant at HFS at 1-877-782-5565 if the hospital believes one of the above exceptions applies.

Providers can download utilization review Attachments A through F from the department's Peer Review Organization (PRO)/Quality Improvement Organization (QIO) webpage.

Any questions regarding the review process may be directed to eQHealth Solutions, Inc. at the toll-free Helpline at 1-800-418-4045. Any questions regarding this notice may be directed to the Bureau of Quality Management at 217-557-5438.

Theresa A. Eagleson, Administrator
Division of Medical Programs