PRIOR AUTHORIZATION OF ELECTIVE PROCEDURE- *BACK SURGERY* REVIEW REQUIREMENTS

Presentation Overview

This presentation is intended to provide education on the prior authorization review process. The following will be explained in detail:

- **Company Overview**
- **Review Request and Submission Timeframe**
- **Exceptions to Prior Authorization Review**
- **Review Process**
  - **→URC Review**
  - **→Physician Review**
- **Reconsideration**
- **Provider Resources**

Company Overview

About eQHealth Solutions

- Serving as Illinois' Quality Improvement Organization (QIO) since 2002.
- Under contract with the Illinois Department of Healthcare and Family Services (HFS), our role is to evaluate the medical necessity, reasonableness and quality of acute inpatient services for HFS fee-for-service participants.

Overview of Services

- Concurrent Review
  - Admission and continued stay review
- Quality of care screening-*during and after hospitalization*
- Retrospective review
  - Prepayment-*after discharge and prior to payment to the hospital*
  - Post-payment review-*after discharge and payment to the hospital*
- Prior Authorization of specific procedures

Review Request and Submission Timeframe

Review Request

» eQHealth will begin accepting requests for prior authorization for elective ICD-9 procedures subject to review on HFS' Attachment F on March1st for scheduled procedures with admissions beginning April 1,2014.

Request Method

» Submit prior authorization review requests electronically, using eQHealth's Web-based system, eQSuite™.

Timeframe

» Review requests must be submitted a minimum of *3 business days up to a maximum of 30 calendar days* prior to the proposed date of the procedure.

Exceptions to Prior Authorization Review

Exceptions 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 your HFS Billing Consultant if one of these exceptions apply.

Review Process

Staff	Functions
First Level reviewers- *Utilization Review Coordinators*	Apply InterQual® procedural criteria to screen for medical necessity of the procedure. **Review Outcome-** 1. Approve procedure based on policy and application of criteria. – Determination rendered within 2 business days from receipt of all required documentation – TAN will be valid for 60 calendar *days* from the date of the *Notice of Approval* letter 2. May request additional information – Review may be pended if additional clinical information is needed to satisfy criteria – *Notice of Request for Additional Information* will be faxed to the hospital's liaison – The hospital will supply additional information within 1 business day from the date on notice – Review will be canceled if the information is not received within the allotted timeframe 3. Refer requests to physician reviewer that cannot be approved at nurse level.

Review Process

Staff	Functions
Second Level Reviewers - *Physicians*	**Review Outcome-** 1. Render approval of procedure. 2. Render an adverse determination (denial) – Only physicians may render an adverse determination for medical necessity. – Physician will make one attempt to contact the attending (surgeon) physician to further discuss the case prior to rendering a determination. The determination is: » Based on hospital documentation that supports medical necessity and appropriateness of setting. » Based on the physician reviewer's clinical experience, judgment and generally accepted standards of healthcare.

Reconsideration Review Process

- If the hospital or physician disagrees with the adverse determination made by eQHealth, a request for reconsideration may be submitted.
- A second eQHealth physician reviewer, who is board certified, and not involved in the initial decision, will review the reconsideration request and make a determination.
- The hospital or treating physician may request an **expedited reconsideration**.
  - A request must be received within 10 business days of the denial notice and prior to the admission (*Reconsideration Request Form for Prior Authorization).*
  - eQHealth will complete the reconsideration review within 3 business days of receipt of a complete reconsideration request.
  - If the reconsideration request is untimely with no good cause, a notice is sent that the request is invalid.

Reconsideration Review Process

Outcome	Details
Reversed- approval of service(s)	*Notice of Reconsideration Determination-Reversed* is issued and the TAN is valid for 60 calendar days from the date of the notice.
Upheld- original denial upheld	*Notice of Reconsideration Determination-Upheld* is issued and there is no other course of action from eQHealth.

Provider Resources

eQHealth Provider Helpline

- Monday through Friday, 8:00 a.m. to 5:00 p.m.
- Submit online inquires via the eQSuite™ helpline module.

Website http://il.eqhs.org

- The Prior Authorization Resources tab includes Provider Manual, Prior Authorization Templates, Reconsideration Request Form and eQSuite ™ User Guide (PowerPoint slides).

Web system – eQSuite™

- Our secure, HIPPA compliant, Web-system offers Providers 24/7 accessibility.

Healthcare and Family (HFS)

- HFS' Informational Notice is available at www.hfs.illinois.gov/hospitals