PRIOR AUTHORIZATION OF ELECTIVE PROCEDURE- *CORONARY ARTERY BYPASS GRAFT(CABG)* 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-CM procedures subject to review on HFS' Attachment F on March 1st 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