Provider
Utilization Review and Quality Assurance Manual

Long-Term Acute Care

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Section A: General Information

1. Request for Certification

Providers must read and be familiar with Healthcare and Family Services' policies and procedures located at http://www.hfs.illinois.gov/handbooks/.

Before submitting a request to eQHealth Solutions, providers must access the beneficiary's eligibility and service limit information through Healthcare and Family Services' (HFS) eligibility verification channels. To utilize, the provider must have the participant's recipient identification number (RIN). Eligibility information consists of whether the participant is eligible for one of HFS' medical programs, and eligibility specific to the date(s) of service.

HFS requests that providers use one of the following resources to verify an individual's eligibility:

Medical Electronic Data Interchange (MEDI) Internet Site
Recipient Eligibility Verification (REV) System
Automated Voice Response System (AVRS) 1-800-842-1461
Health Benefits Provider line at 1-800-226-0768 (press option 6) or 217-557-6544

Requests for certification should be submitted to eQHealth after:

1. Confirmation by the treating physician or designee regarding the need for acute inpatient services and anticipated length of stay.

2. Receipt of a physician order for **inpatient** admission (signed and dated), including the admitting diagnosis.

3. Long Term Acute Care hospitals must request certification of all admitting diagnoses.

2. About eQHealth Solutions, Inc.

eQHealth Solutions, Inc. (eQHealth), under contract to Healthcare and Family Services (HFS) since 2002, serves as Illinois' Quality Improvement Organization (QIO). eQHealth Solutions' role is to evaluate the medical necessity and quality of acute inpatient services for HFS fee-for-service participants. eQHealth provides certification for admissions and continued stay, as well as retrospective pre- and post-payment review of acute inpatient care in medical/surgical and psychiatric settings. eQHealth also provides quality of services review, determining the medical necessity, reasonableness and appropriateness of care using telephonic and Web-based interactions. Dedicated to continuous quality improvement, eQHealth offers educational training and outreach for HFS medical program providers to support these activities.

3. eQHealth Contact Information

Business address	2050-10 Finley Road Lombard, IL 60148
Business telephone *(Monday – Friday, 8 a.m. – 5 p.m.)*	(630) 317-5100
Business fax	(630) 317-5101
Toll-free certification line *(Monday – Friday, 7 a.m. – 5 p.m.)*	(800) 418-4033
Toll-free fax for reconsideration requests; addtl information	(800) 418-4039
Provider helpline *(Monday – Friday, 8 a.m. – 5 p.m.)*	(800) 418-4045
Web site address	http://il.eqhs.org

4. Provider Services and Resources

a. Provider Helpline

A toll-free provider helpline is available to assist the Provider community at (800) 418-4045. If providers have any questions regarding eQHealth Solutions' program, processes or notifications, helpline staff is available Monday through Friday, from 8 am to 5 pm, CT. Hospitals may also submit helpline inquiries online through eQSuite™, accessible from our Website homepage.

b. Provider Education and Training

eQHealth offers free Web-based training sessions. Using a single internet connection and a conference phone at the hospital, any number of staff may attend. For more information regarding future provider education sessions, click on the Training/Education tab at il.eqhs.org.

eQHealth Solutions keeps the provider community informed of program changes and updates through communications sent by mail or fax. These provider communications, or "Provider Updates", can also be viewed online at http://il.eqhs.org

c. eQHealth Solutions' Web system

i. Hospital Communications & Resources

Hospitals can access a variety of useful information on our Website at http://il.eqhs.org including:

- General policy and procedure information in the *Provider Manual*.
- eQHealth Solutions *Provider Updates* and a link to HFS *Informational Notices*.
- Frequently asked questions (FAQs) regarding the utilization review program.
- User guides for *Web-based Review System* and *Provider Web Reports*.
- Provider forms including hospital contact change, reconsideration request form, et al.

ii. Access to Submit Web Reviews and Run Hospital Specific Reports

Hospitals may register for a free Web account (see section 5.c below for more information).

The Web-based review system is accessed through a link (eQSuite) on eQHealth's Web site and offers providers the flexibility of submitting review requests online 24 hours a day, 365 days a year. Web reviews will be processed by a Utilization Review Coordinator (URC) within one business day from the date of receipt of all necessary information.

This convenient, user-friendly system allows hospitals to perform admission and continued stay review requests, view previous requests, check real-time status of Web review requests, respond to requests for additional information, and easily submit discharge dates online. For detailed instructions on how to use the Web-based review system, download the *eQHealth Solutions Web User Guide from the Provider Resources tab on our Website.*

eQHealth also offers free training sessions to instruct hospitals how to use the Web-based review system and access provider-specific reports. Provider specific reports are accessed through the "eQSuite". Hospitals may use these reports to obtain real-time status of reviews, compare their hospital review data to others throughout the state, and view graphical representations of the data. Hospitals may also access the online helpline r from this Web-based system. For more information about the provider Web reports available, visit the Provider Resources tab at http://il.eqhs.org.

5. Hospital Contacts

a. eQHealth Liaisons

The eQHealth (Medicaid) Liaison is selected by a member of hospital administration. His/her role is to be the primary contact between eQHealth Solutions and the hospital. All provider communications, notifications, and letters are sent to this liaison (with the exception of Quality). It is important to keep the eQHealth Liaison contact information accurate to ensure all utilization review information is received.

b. eQHealth Quality Contact

The eQHealth quality contact is selected by a member of hospital administration and is the primary contact between eQHealth Solutions and the hospital regarding quality of care.

c. Web Administrator

To access eQHealth Solutions' Web-based review system and provider-specific reports, each hospital may register for a free Web account and must designate a Web administrator. The Web administrator assigns access rights and maintains log-in IDs for all eQHealth Web users at their facility. They are also responsible for inactivating users who should no longer have access.

d. LTAC Readiness Review and Compliance Monitoring Contact (LTAC quality contact)

The eQHealth LTAC quality contact is selected by a member of hospital administration. His/her role is to be the primary readiness review and compliance monitoring contact between eQHealth Solutions and the hospital. All communication regarding the readiness review process, the provider toolkit and the biannual compliance monitoring will be sent to this liaison.

e. Hospital CEO and CFO

The hospital CEO or CFO information is used as appropriate approval for assigning the eQHealth Liaison at each facility. This contact information may also be used in targeted communications.

It is vital to keep hospital contact information current. Hospital contacts may be changed any time by completing a Hospital Contact Form, located in the Quick Resource section of our Web site homepage, or under the Provider Resources tab.

Section B: Utilization Review

eQHealth Solutions is contracted by Healthcare and Family Services (HFS) to perform concurrent admission and continued stay review, and quality of care screening (during and after hospitalization), retrospective prepayment review (after discharge and prior to payment to the hospital), and post-payment review (after discharge and payment to the hospital) to determine the following:

- Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury.
- The medical necessity, reasonableness and appropriateness of acute inpatient LTAC hospital admissions and discharges.
- The completeness, adequacy and quality of hospital care provided.

- Whether the quality of the services meet professionally recognized standards of health care.
- Whether those services furnished or proposed to be furnished on an acute inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically at a lower level of care.
- The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of 42 CFR 412.82 and 412.84.

1. Concurrent Review

Beginning with admissions on or after October 1st, 2010 all LTAC admissions are subject to mandatory concurrent review. eQHealth will be conducting concurrent review via our toll-free certification line until November 1, 2010. After November 1, 2010 all reviews can be submitted online through eQHealth's Web-based review system.

eQHealth conducts utilization review to determine the medical necessity and appropriateness of long term acute care hospitalization. As defined by HFS' program policies the review begins with verification of a patient's eligibility as HFS fee-for service participant and the admitting diagnosis. The submitted diagnosis must meet the definition of "admit diagnosis" as defined in the National Uniform Billing Committee Official UB 04 Data Specifications Manual. When review is not required because of coverage issues, eQHealth Solutions cancels the review and a *Notice of Cancelled Request for Review Certification* is sent to the eQHealth Liaison.

We conduct two types of concurrent review, admission and continued stay.

a. **Admission Review**

The review process is initiated when a hospital or physician submits a request for admission certification. The request should be submitted within 24 hours of admission or shortly thereafter, while the patient is still admitted to inpatient care. The only time a concurrent review may be performed after discharge is for "short stay" hospitalizations of three days or less. Short stays must be reviewed within seven days of the discharge date (for more information about the short stay review policy, see Section B.1.a.iii).

URCs are registered nurses who receive the hospitals' review requests by phone or by Web. They apply LTAC specific InterQual® criteria to determine medical necessity for admission. If the criteria are satisfied the request is certified by the URC. When criteria are met, *Thomson Healthcare's Length of Stay Norms* for the North Central Region are referenced as a guide in the assignment of length of stay and the next review point.

When criteria are not satisfied or the requested length of stay exceeds what the URC can certify, the request is referred to a physician reviewer. The eQHealth Liaison receives written notification that a PR referral has occurred. Hospitals are encouraged to contact the treating physician to advise them of the referral and that (s)he may be contacted by a PR from eQHealth Solutions to discuss the hospitalization. NOTE: If treating physician differs than the attending or there is an alternate phone number, it is important for hospitals to give the treating physician's contact information to eQHealth as part of the review process.

If insufficient clinical information is provided, the URC will pend the review for additional information. All review notifications of certification, additional information or non-certification (denial) are explained in Section 4. In addition to evaluating medical necessity, our URC's also conduct a quality of care screening specific to the clinical setting.

i. ***Physician Reviewer Process:*** The physician review is based on medical judgment and nationally recognized clinical care standards. All efforts are made to match the care being reviewed to a physician of the same specialty. Consideration is also given to the geographic region, size and type of hospital in which the services are being delivered. The PR may approve the care and assign the length of stay based on information provided. Only a physician reviewer is able to render an adverse determination. Prior to rendering an adverse determination, the PR will make one attempt to reach the treating physician to discuss the case.

When non-certifications are rendered both LTAC hospital and the attending physician receive written notification. Additionally, LTAC hospitals receive telephonic notification of the outcome. Reconsideration of this determination may be requested using the process outlined in Section B3.

ii. ***URC Time frames:*** URC certification determination is rendered at the time of the telephonic review request or within one business day from the receipt of all necessary information. Web review requests will be processed by the URC within one business day from receipt of all necessary information – excluding weekends and designated Federal and State holidays. Web review requests received after 5 p.m. are considered to be received the next business day. Written notice is issued to the eQHealth Liaison on the day the determination is rendered (see Section 4 for a list of notifications).

iii. ***PR Time frames:*** If a case is referred for physician review, a *Physician Peer Reviewer (PR) Referral Notice* is automatically sent to the hospital eQHealth Liaison. PR determinations are rendered within two business days of the review request and receipt of all necessary information.

If there is a medical necessity non-certification (denial), the treating physician is notified verbally at the time of the peer-to-peer discussion. It is important for hospitals to give the treating physician's contact information to eQHealth Solutions as part of the review process (if treating physician differs than the attending or there is an alternate phone number).The review requestor is provided verbal notification within one business day of the adverse determination. Please note that if the requestor's voice mail does not state that it is "confidential", a verbal notification with patient information will not be left. Additionally, written notice of the adverse determination is sent to both the attending physician and the hospital's eQHealth Liaison.

b. **Continued Stay Review**

Long term acute care hospitalizations are reviewed for each day of care. For these hospitalizations, when the admission is certified and the provider anticipates additional days of care beyond the last date certified, continued stay review is performed.

Our URC again applies InterQual® criteria to assess the medical necessity of continued acute inpatient care. If the criteria are satisfied, the number of certified days is extended. In addition to evaluating medical necessity, our URC's also conduct a quality of care screening specific to the clinical setting. When the URC identifies days of care or quality screens that fail to satisfy the criteria, the record is referred to our PR.

To facilitate the continued stay review process, eQHealth Solution sends the hospital's designated eQHealth Liaison a daily list that shows all certifications. After November 1st, 2010 LTAC hospitals may use eQHealth's Web-based review system to verify the admission date and conveniently report the discharge dates.

Continued stay must be requested by the hospital one day prior to the last day certified to ensure that all inpatient days will be reviewed prior to billing HFS. If an admission was certified by eQHealth but the patient was discharged prior to the hospital's request for

continued stay review, the hospital may still request review for the remaining days only if the claim for services has not been submitted.

NOTE: The hospital must request the continued stay days, provide the discharge date and submit the bill within HFS' 180 day claims submission timeframe. See HFS Informational Notices at www.hfs.illinois.gov/hospitals.

i. ***URC Time frames:*** URC certification determination is rendered at the time of the telephonic review request or within one business day from the receipt of all necessary information. Web review requests will be processed by the URC within one business day from receipt of all necessary information – excluding weekends and designated Federal and State holidays. Web review requests received after 5 p.m. are considered to be received the next business day. Written notice is issued to the eQHealth Liaison on the day the determination is rendered (see Section 4 for a list of notifications).

ii. ***PR Time frames:*** If a case is referred for physician review, a *Physician Peer Reviewer (PR) Referral Notice* is automatically sent to the hospital eQHealth Liaison. PR determinations are rendered within one business day of the review request and receipt of all necessary information.

If there is a medical necessity non-certification (denial), the treating physician is notified verbally at the time of the peer-to-peer discussion. It is important for hospitals to give the treating physician's contact information to eQHealth Solutions as part of the review process (if treating physician differs than the attending or there is an alternate phone number).The review requestor is provided verbal notification within one business day of the adverse determination. Please note that if the requestor's voice mail does not state that it is "confidential", a verbal notification with patient information will not be left. Additionally, written notice of the adverse determination is sent to both the attending physician and the hospital's eQHealth Liaison.

For an overview of the Physician Review process please refer to the Admission/Continued Stay Concurrent Review Process flowchart in Appendix A of this document.

c. **Short Stay Review**

For admissions involving short stays of three days or less, hospitals may submit review requests within seven calendar days of discharge. Review requests may be submitted online, 24 hours a day or by calling the toll-free LTAC certification line at (800) 418-3970, Monday through Friday, 7 a.m. to 5 p.m., except on designated Federal and State holidays.

Web review requests will be processed by the URC within one business day from the date of receipt of all necessary information – excluding weekends and designated Federal and State holidays.

d. **Methods of Submission for Concurrent Review**

Effective with admissions on and after October 1, 2010, requests for all LTAC admission and continued stay reviews may be submitted:

1) Beginning October 1, 2010 – Call our toll-free LTAC certification line 800-418-3970, Monday through Friday, 7 a.m. to 5 p.m., except on designated Federal and State holidays and

2) Beginning November 1, 2010 – added option of submitting reviews online through eQHealth's Web-based review system, 24 hours a day, 365 days a year.

Web review requests will be processed by the Utilization Review Coordinator (URC) within one business day from the date of receipt of all necessary information – excluding weekends and designated Federal and State holidays. For list of holidays, see Appendix A.

IMPORTANT NOTE: When billing HFS for certified acute inpatient care, the hospital must report the same admitting diagnosis code submitted to eQHealth Solutions during the certification process on the UB-92/UB-04 claim form or 837I electronic claim submittal.

e. **Concurrent Quality of Care Screening**

Along with the determination of medical necessity quality screening is also conducted during concurrent review. URCs *screen* for potential quality issues based on the clinical information provided. If the information suggests there is, or may be immediate and significant risk to the patient, our physician will contact the treating physician to discuss the situation. In some cases, eQHealth Solutions may request that the hospital submit a medical record for post-payment review after the patient's discharge so that a complete quality review may be performed.

f. **Exceptions to Mandatory Concurrent Review**

HFS allows exceptions to mandatory concurrent review when:

- An HFS participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the HFS participant was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the HFS participant's Managed Care Organization (MCO) enrollment at the time of admission.
- The HFS participant remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description.

Providers that do not follow the concurrent review process will receive remittance claim rejections with the new error code A88 – "No Certification on File" from HFS. If that claim meets one of the exceptions to mandatory concurrent review the provider may re-submit with a paper claim to their HFS billing consultant, along with a cover memo explaining the exception and any supporting documentation (i.e. exceptions relating to Medicare Part A exhaust require Medicare verification of exhausted benefits). These claims will be manually reviewed by HFS' QIO program management and billing staff and if approved, will suspend for retrospective prepayment review. If the review is cancelled and the claim is re-submitted, the initial cover memo explaining the exception must be submitted with the claim. Those paper claims with exceptions that are not approved will not be payable.

g. **Children's Mental Health**

In an effort to improve children's mental health, Illinois developed an enhanced Screening, Assessment and Support Services (SASS) system for children, including adolescents, experiencing a mental health crisis.

This initiative is part of the Children's Mental Health Act of 2003 (Public Act 93-0495), which was signed into law on August 8, 2003.

This initiative involves a partnership between the Department of Human Services, the Department of Healthcare and Family Services and the Department of Children and Family Services. It creates a single statewide system to serve children experiencing a mental health crisis whose care will require public funding from one of the three agencies. The program emphasizes a

family-friendly, single point of entry for all children using this system and will ensure that children receive crisis services in the most appropriate setting.

Additional information regarding the Children's Mental Health Program is available on HFS' Web site at http://www.hfs.illinois.gov/sass

i. The Role of SASS

The SASS program has two components: A Crisis and Referral Entry System known as CARES that operates through a toll-free phone line with geographically dispersed screening agents known as SASS providers. The handbook for Providers of Screening, Assessment and Support Services (CMH-200) can be downloaded from HFS' Web site at www.hfs.illinois.gov/handbooks/.

For child and adolescent psychiatric hospitalizations, the hospital must notify CARES prior to admission into acute inpatient care. CARES will assign a SASS provider, who must conduct an assessment and be involved in the discharge planning of the patient. *Unless CARES records their involvement in the admission, eQHealth Solutions will not be able to proceed with the review*. The hospital may contact CARES at (800) 345-9049.

2. Retrospective Review

Retrospective review requires a copy of the HFS participant's complete medical record. During retrospective review, the medical necessity of the admission, each day of care and the appropriateness of invasive procedures are reviewed. In addition, eQHealth Solutions conducts quality of care review and assesses for critical billing errors. We conduct two types of retrospective review: prepayment and post-payment.

a. **Prepayment Review**

Claims submitted to HFS for acute inpatient services may be selected for retrospective prepayment review when the admission was not certified through the concurrent review process and met one of HFS' exceptions to mandatory concurrent review. (See Section 1.f for further explanation of mandatory concurrent review exceptions).

Each hospital will be sent a notification of those cases selected for review. The notice will be faxed to the hospital eQHealth's Liaison with a case listing and a tracking sheet for each of the cases selected for review. The hospital must submit the medical record for each of the cases, complete and attach the tracking sheet and securely ship the records to eQHealth Solutions within 14 calendar days from the date of the *Notice of Selection of Medical Records for Retrospective Review*.

Hospitals will be reimbursed by eQHealth at 10 cents per page or 20 cents for double sided pages for copying reimbursement. Under HFS contract, eQHealth is afforded 44 calendar days to complete the review.

Prior to initiating a retrospective admission review, the URC first checks for any critical billing errors that could affect reimbursement. If such an error is identified, the review is cancelled and the hospital must re-submit the claim to HFS.

In the absence of a critical billing error, the URC then performs the review to confirm that long term acute inpatient care was medically necessary at the time of admission and to verify the necessity of invasive procedures. The URC applies LTAC InterQual® criteria to assess the medical necessity of admission and each day of care. If any days of care do not satisfy criteria, the record is referred for physician review. In addition the Centers for Medicare & Medicaid Services (CMS) quality of care concern categories are applied (See Section C.)

Failure to meet medical necessity or quality of care categories, results in a referral for physician

peer review. Notification of this referral will be sent to the hospital's eQHealth Liaison who is encouraged to contact the treating physician to discuss the referral and inform him/her that eQHealth's PR may contact. Also, upon receipt of the *Physician Referral Notice* for Retrospective Prepayment Review, the facility or attending physician has seven calendar days to submit any relevant, additional information to eQHealth Solutions that may assist the PR in making a determination.

Based on the information provided, the physician reviewer may approve the entire hospitalization, deny specific days of care or deny the entire hospitalization. For non-certifications written notice will be issued informing the hospital and physician of the determination (see Section I.b.ii). Reconsideration of the determination may be requested according to the process described in *Section B3.*

b. **Post-payment Review**

Post-payment review is conducted on a random sample of hospitalizations selected by eQHealth from HFS paid claims data.

Post-payment review includes evaluation of the medical necessity of the hospitalization, each day of care and the appropriateness of invasive procedures. In addition, eQHealth conducts quality of care review, validates the clinical information provided during admission and continued stay review, and monitors for critical billing errors.

Monthly each hospital will be sent a notification of those cases selected for review. The notice will be faxed to the hospital eQHealth's Liaison with a case listing and a tracking sheet for each of the cases selected for review. The hospital must submit the medical record for each of the cases, complete and attach the tracking sheet and securely ship the records to eQHealth Solutions within 14 calendar days from the date of the *Notice of Selection of Medical Records for Retrospective Review*. Hospitals will be reimbursed by eQHealth at 10 cents per page or 20 cents for double sided pages for copying reimbursement. Under HFS contract, eQHealth is afforded 60 calendar days to complete the review.

The URC and physician review process mirrors that of prepayment review with the exception the reviews are not cancelled due to critical billing errors.

3. Reconsideration

Reconsideration of a non-certification (denial) determination maybe requested in writing by the hospital or treating physician as outlined in all notice of denials. *eQHealth reconsideration request forms may be downloaded from the eQHealth Web site*. ***The pertinent clinical information supporting the medical necessity of the denied days must be provided with the request for a standard reconsideration.***

The request must include:

- The patient's name, hospital, dates of service, recipient identification number (RIN), the treating physician's name and telephone number, and should include a copy of the non-certification (denial) notice.

Standard Reconsideration

A standard reconsideration may be requested within 60 calendar days of the denial notification. An acknowledgement of the receipt of request will be sent to the requestor (either the hospital's eQHealth Liaison or the attending physician). This notification explains the procedure for mailing in additional information within 10 calendar days from the date on the notification. After receipt of all valid and necessary information, eQHealth Solutions is allotted 30 calendar days to render a determination.

Expedited Reconsideration

An expedited reconsideration is only available for hospitalizations reviewed through the concurrent review method, and the request must be received by eQHealth Solutions while the patient is still hospitalized. The hospital or physician may send the request for expedited reconsideration along with any additional, pertinent medical information or supporting documentation via mail, facsimile or other acceptable means to eQHealth Solutions. Expedited reconsideration is **not** available after the patient's discharge from the hospital.

For expedited reconsiderations, a determination by a physician reviewer is made within three business days of the receipt of all valid, necessary information.

4. Provider Notifications

a. **Admission/Concurrent Review Notifications**

Notice of Review Approval – This notice is issued to the hospital's eQHealth Liaison when a request for admission or concurrent/continued stay is certified by the Utilization Review Coordinator (URC) or the Physician Peer Reviewer (PR).

The *Notice of Review Approva*l informs the hospital of the certification, the admit diagnosis code used during the admission certification process, the treatment authorization number (TAN), the number of days certified as well as the next review point.

Notice of Cancelled Review for Review Certification – This notice is issued to the hospital's eQHealth Liaison when a request for certification is received and review will not occur due to non-clinical reasons, e.g., the patient is not eligible for Medicaid, etc.

Request for Additional Information – Lack of Clinical Information Notice – This notice is issued to the hospital's eQHealth Liaison when the URC determines that the request for certification does not provide sufficient clinical information necessary to render a determination. The hospital must supply the requested information within one business day for the review to continue.

Physician Peer Reviewer (PR) Referral Notice – This notice is issued to inform the hospital's eQHealth Liaison that a request for certification has been referred to a PR.

Notice of Denial – Certification Request – This denial notice is issued to the hospital's eQHealth Liaison when, based on available clinical information, the PR was unable to certify the medical necessity of the admission or continued stay.

b. **Retrospective Review Notifications**

Notice of Selection of Medical Records for Offsite Review – This notice is sent for cases selected for either prepayment or post-payment review. This notice accompanies a listing of cases selected for off-site review and is faxed to the hospital's eQHealth Liaison. The requested medical records must be copied and submitted to the address designated, and received by the date of notice. An *Offsite Review Inventory Tracking Sheet* is also provided for each record that is to be copied and sent to eQHealth Solutions. ***The corresponding tracking sheet must be attached to the copy of the medical record prior to submission to eQHealth Solutions.***

Case Listing for Offsite Review – This is the list of cases that have been selected for off-site review. The list is faxed to the hospital's eQHealth Liaison with the *Notice of Selection of Medical Records for Offsite Review* and an *Offsite Review Inventory Tracking Sheet* for each selected record.

Offsite Review Inventory Tracking Sheet – An *Offsite Review Inventory Tracking Sheet* for each record selected for offsite review is faxed to the hospital's eQHealth Liaison with the

Notice of Selection of Medical Records for Offsite Review and the *Case Listing for Offsite Review*.

The hospital should record the page count, date, sign and check off the appropriate box if the case is an exception to concurrent review. The corresponding tracking sheet must be attached to the copy of the medical record prior to submission to eQHealth Solutions.

Notice of Cancelled Review – Prepayment Review – This notice is issued to the hospital's eQHealth Liaison when a case has been selected for prepayment review but the chart is not available. The claim must be resubmitted to HFS when the chart becomes available for review. Hospitals do not need to attach this notice to the resubmitted claim, but if the claim is for an exception to mandatory concurrent review, a cover memo stating the exception must be included with the claim to HFS. ***Note: Copies of medical records should NOT be sent to HFS or automatically submitted to eQHealth Solutions. Rather, eQHealth will send a Notice of Selection of Medical Records for Offsite Review when HFS notifies them that the case has been re-selected for prepayment review.***

Notice of Incorrect Billing – Prepayment Review – This notice is issued to the hospital's eQHealth Liaison when care has been billed incorrectly and cannot be reviewed as billed. Most frequently the incorrect Category of Service (COS) was billed or more than one COS was provided (such as medical and psychiatric care in the same stay) and the incorrect COS was used for the days being billed. This notice is also issued when the incorrect discharge status or incorrect admission and/or discharge dates result in the billing of an incorrect length of stay.

Notice of Cancelled Review Lack of Clinical Information – Prepayment Review – This notice is issued to the hospital's eQHealth Liaison when clinical information necessary to render a determination was not provided within the allowed timeframes. The claim must be resubmitted to HFS when the information or chart is available. Hospitals should not attach this notice to the resubmitted claim. Charts should not be sent to HFS. Hospitals should not automatically submit a copy of the information to eQHealth Solutions if this notice is received. eQHealth Solutions will request a copy of the record after they receive notification by HFS that the record has been re-selected for prepayment review.

Physician Peer Reviewer Referral Notice – Prepayment Review – This notice is issued to the eQHealth Liaison when the URC determines that PR referral is required. The purpose of the notice is to allow the hospital time to review and discuss the case with the treating physician and to encourage the treating physician to participate in peer-to-peer discussion should it be necessary.

Notice of Admission Denial– Prepayment Review – This notice is issued to the hospital's eQHealth Liaison and the attending physician when a PR is unable to substantiate the medical necessity of acute inpatient hospitalization. This results in denial of payment by HFS for the entire stay.

Notice of Length of Stay Denial – This notice is issued to the hospital's eQHealth Liaison and attending physician when a PR determines that admission was medically necessary, but he or she is unable to substantiate the medical necessity of the entire length of stay. Payment is denied by HFS for the portion of the stay for which medical necessity is not substantiated for per diem reimbursed hospitalizations.

Reconsideration of a non-certification (denial) determination maybe requested in writing by the hospital or treating physician as outlined in all notice of denials. *eQHealth reconsideration request forms may be downloaded from the eQHealth Web site*. ***The pertinent clinical information supporting the medical necessity of the denied days must be provided with the request for a standard reconsideration.***

c. **Retrospective Reconsideration Notifications**

Notice of Invalid Request for Reconsideration – This notice is issued to the requestor (either hospital's eQHealth Liaison or physician) when a request for reconsideration exceeds the allowed 60 day timeframe for submitting the request.

Notice of Reconsideration Determination – Reversed or
Notice of Reconsideration Determination (Modified or Upheld) – This notice is issued to inform the hospital's eQHealth Liaison and attending physician of the reconsideration outcome of a prior denial determination. The original denial may be:

- Upheld - Original denial is upheld, and payment will be denied for that care.
- Modified - Original denial has been modified but not totally reversed. The reconsideration has resulted in medical necessity certification of one or more of the days of care that were originally denied. In order to receive payment for the days that are now certified, this care must be re-billed with the notice attached.
- Reversed - Original denial is completely reversed and the admission or all days of care are certified as medically necessary. In order to receive payment, the care must be re-billed with the notice attached.

Acknowledgement of Receipt of Request for Reconsideration – This notice is issued to the requestor (either the hospital's eQHealth Liaison or attending physician) to acknowledge receipt of a request for reconsideration. The hospital and the attending physician are afforded 10 calendar days to submit additional information to be considered.

Section B: Retrospective Quality Review

1. Retrospective Quality Review Process

Under contract with Healthcare and Family Services, eQHealth Solutions performs quality of care review to determine the completeness, adequacy and quality of hospital inpatient care. Objectives of the retrospective quality review process are:

- To perform quality review to determine whether the quality of services provided meet professionally recognized standards of healthcare.
- To work with providers and practitioners to promote patient safety and improve care delivery through peer-to-peer discussions, consultation and quality improvement plans.

Retrospective quality of care review is conducted by applying the Centers for Medicare & Medicaid Services (CMS) quality of care concern categories. If a potential quality of care concern is identified, it is referred to a physician reviewer. The PR reviews the identified concern(s) and determines whether a quality of care concern exists, the seriousness or risk of the concern, and the source of problem.

When a potential serious quality care concern is identified at the first level, our PR attempts to contact the treating physician to discuss the concern and obtain all pertinent information prior to rendering a determination. Our PR may determine that a quality concern is present and assign a patient risk category with the source of problem or may determine that no quality concern exists.

Serious quality concerns confirmed at the second-level physician review are referred to a physician peer review panel for evaluation. Each quality review panel is comprised of three or more board certified physicians representing the medical specialty of the attending physician or the type of care under review.

Prior to the panel meeting, all cited parties are invited to provide additional information and participate telephonically during the panel's deliberation. Based on all information provided, the panel may:

- Validate the serious quality concern and request a quality improvement plan (QIP),
- Downgrade the concern to moderate or minimum,
- Determine that no quality issue exists.

The panel then monitors the QIPs and related indicators to assess the plan's effectiveness in resolving the quality of care concern(s).

a. **Quality Notifications and Timelines**

If the quality issue involves hospital departments only, a letter is mailed to the hospital's eQHealth's Quality contact (if different from eQHealth Liaison).

If the issue involves any physicians or physicians and the hospital, letters are mailed to both the hospital's eQHealth Quality contact and the cited physicians. The hospital has 20 calendar days in which to:

- Submit additional written information via fax or mail for a to review the case, and/or
- Request peer-to-peer discussion

b. **Quality Improvement Plan**

A Quality Improvement Plan (QIP) is requested when the care was grossly and flagrantly unacceptable and is validated by a panel of physicians. A QIP can also be requested if there is a pattern of care which fails to follow accepted guidelines.

c. **QIP Reporting and Monitoring**

Upon approval of the hospital's submitted quality improvement plan by eQHealth Solutions' regional quality review panel, a copy of the approved QIP is sent to HFS and the Bureau of Medicaid Integrity.

The length of time required for quality improvement plan (QIP) monitoring is case-specific, based on the monitoring results. The monitored results need to support that the QIP is achieving and maintaining the target goals. Three to four successive quarters of monitoring is typical. However, monitoring may be extended for a longer period or modifications may be requested if the QIP does not appear to be resolving the quality issue.

eQHealth Solutions reports the Panel's recommendations to HFS.

2. Provider Quality Notifications

Notice of Serious Quality Issue – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) via overnight mail. It informs that, based on the review of the medical record and all information provided, our Physician Peer Reviewer (PR) has determined potential flagrant quality of care issue. The notice includes definition of a serious quality issue, a summary of the specific concern and clinical rationale for the determination. It also identifies the source of problem(s) and includes instructions to submit additional information within 15 calendar days if the hospital or attending physician disagrees with the findings.

Notice of Confirmed Serious Quality Issue – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) after initial notice was received and additional information was forwarded to eQHealth Solutions. It also informs that a PR has reviewed the case, along with the additional information provided, including a copy of the medical record and has confirmed the quality issue. The notice also includes a summary of potential concern with the previously assigned severity level, as well as the summary of confirmed concern

and severity level assignment. It also states that the case is being forwarded to eQHealth's physician review panel for validation of serious quality issue and gives 15 calendar days to submit additional information deemed appropriate by the physician review panel. The phone number and address for eQHealth's quality review department are included for contact purposes.

Notice of Non-Confirmed Quality Issue – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) and is sent after an initial *Notice of Potential Severity Level Quality Issue* was issued. It informs that a second Physician Peer Reviewer reviewed the case and all information available, including a copy of the medical record and has made a determination. The notice also includes a summary of the concern, clinical rationale and final determination of the quality issue being resolved or modified.

Notice of Panel Validation Serious Quality of Care Concern/QIP Request – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) after the *Notice of Confirmed Serious Quality Issue* is issued and eQHealth's physician peer review panel has reviewed and confirmed the quality concern. It includes the summary of confirmed quality concern and previously assigned severity level, as well as a summary of validated quality concern and final determination. A quality improvement plan (QIP) is requested to be submitted within 45 calendar days of this notice.. The QIP will be evaluated by eQHealth's peer review panel that will accept it as submitted or request modifications to ensure the quality concern is adequately addressed to prevent future occurrences. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Panel Determination of Non-Confirmed Quality of Care Concern – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited). This notice is sent after the *Notice of Confirmed Serious Quality Issue* is issued and eQHealth's physician peer review panel has reviewed all information available, including the medical record and made a determination of a non-confirmed quality issue. Notice provides a summary of the concern, clinical rationale and a final determination that the quality issue has been resolved or modified. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Panel Approval of QIP – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited), after receipt of quality improvement plan (QIP) for referenced case(s). It informs party(ies) that eQHealth's quality review panel has reviewed the QIP and determined it is sufficient to address the quality concern(s) identified and to prevent future occurrences and accepts it as submitted. The notice explains that the panel recommends monitoring for four successive quarters to ensure and maintain improvement and provides the first monitoring report due date. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Panel Approval of Revised QIP – This notice is sent to hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) after receipt of the hospital's revised quality improvement plan (QIP) for referenced case(s). It informs party(ies) that eQHealth's quality review panel has reviewed the QIP and determined, that with modifications, it is now sufficient to address the quality concern(s) identified and to prevent future occurrences and accepts it as submitted. The notice explains that the panel recommends monitoring for four successive quarters to ensure and maintain improvement and provides the first monitoring report due date. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Panel Requests Modification of QIP – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited), after receipt of the hospital's

quality improvement plan (QIP) for referenced case(s). It informs that eQHealth's quality review panel reviewed the QIP and determined that essential elements of the QIP were absent or not clearly defined and is not sufficiently comprehensive to address the quality concern(s)/pattern(s) identified to ensure there will be no future occurrences. A request for a revised QIP is stated with a due date of 15 calendar days from the date of the notice. This notice also states that HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Quarterly Approval of QIP Monitoring– This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited), after receipt of the hospital's QIP monitoring report. It also informs that eQHealth's quality review panel has determined that the monitoring plan is sufficiently comprehensive to address the quality concern(s)/pattern(s) identified, to ensure there will be no future occurrences. The notice explains that the panel accepts the QIP monitoring report and recommends continued monitoring to ensure and maintain improvement and gives the timeline and due date for the next QIP monitoring report.

Notice of Approval of QIP Resolution – This notice is sent to the hospital's eQHealth Quality contact and/or the attending physician (whichever is cited) after receipt of the hospital's QIP monitoring report. The notice also informs that eQHealth's quality review panel has determined that the monitoring plan is sufficiently comprehensive to address the quality concern(s)/pattern(s) identified, to ensure there will be no future occurrences. The panel accepts the QIP monitoring report as submitted and has determined that it is no longer necessary to monitor the quality improvement efforts regarding this particular quality concern. The issue is considered resolved.

Notice of Potential Quality of Care Concern Pattern – This notice is sent to the eQHealth Quality contact and/or the attending physician (whichever is cited). On a quarterly basis, eQHealth identifies cases with a quality of care concern by provider or practitioner exceeding 5% of that quarter's reviewed cases. These cases are referred to a physician reviewer for confirmation of a quality pattern. The Provider and/or Physician are given the opportunity to address the identified quality of care pattern.

Notice of Panel Validation Quality of Care Concern Pattern/QIP – This notice is sent to the eQHealth Quality contact and/or the attending physician (whichever is cited) when eQHealth's physician panel reviewed and validated a pattern of quality of care concerns. This is after the hospital received notice of Potential Quality of Care Concern Pattern and afforded the opportunity to address the issue(s). A quality improvement plan (QIP) is requested to be submitted within 45 calendar days of this notice.

Notice of Quality of Care Concern Pattern – Care Failed to Follow Accepted Guidelines – This notice is sent to the eQHealth Quality contact and/or the attending physician (whichever is cited). On a quarterly basis, eQHealth identifies cases with a pattern of quality concern – Care Failed to Follow Accepted guidelines by provider or practitioner exceeding 5% of that quarter's reviewed cases. These cases are referred to a physician reviewer for confirmation of a quality pattern. The Provider and/or Physician are given the opportunity to address the identified quality of care pattern.

Appendix A

eQHealth Solutions Process Flowcharts

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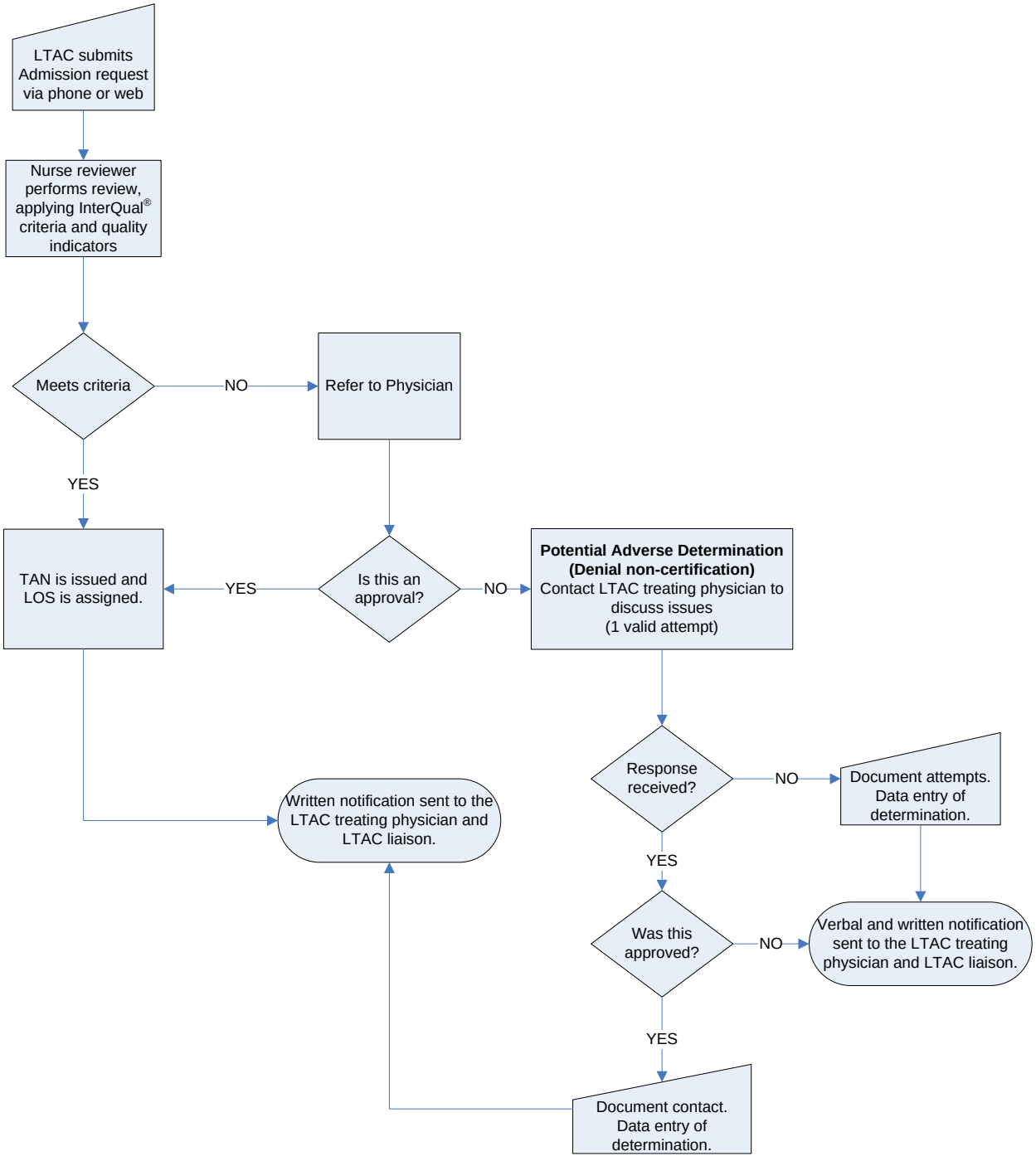
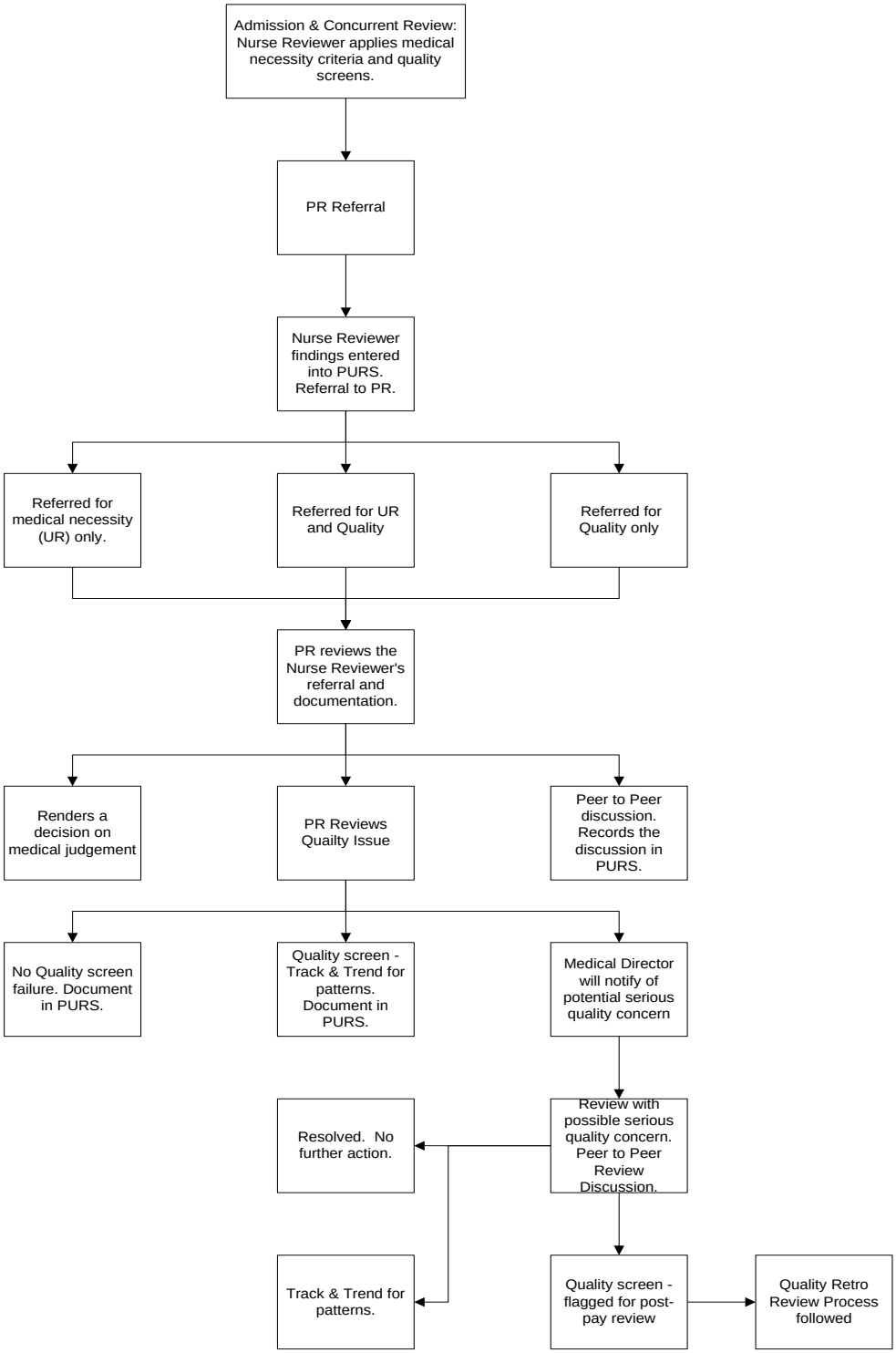
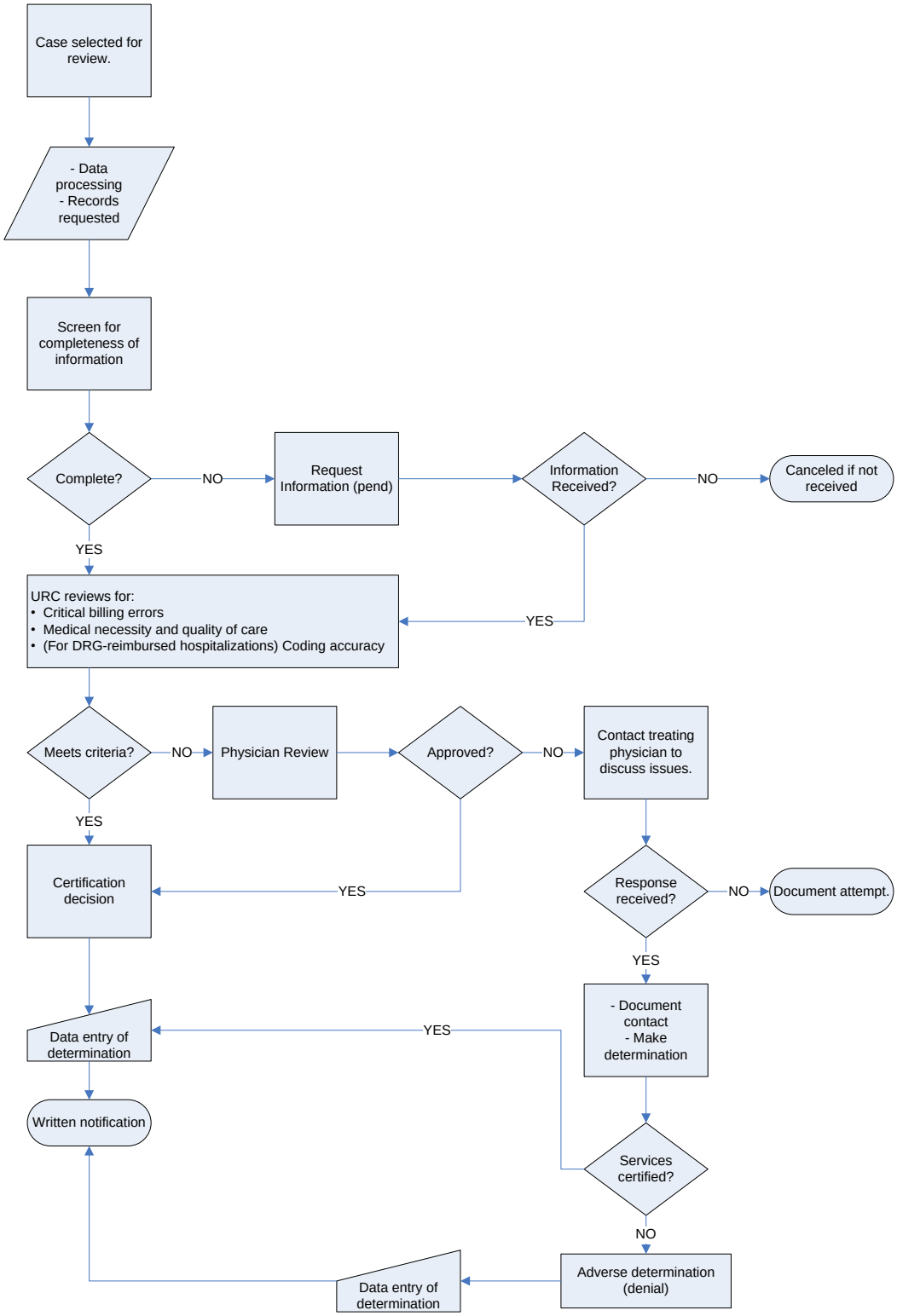
LONG TERM ACUTE CARE (LTAC)
ADMISSION CONCURRENT REVIEW PROCESS



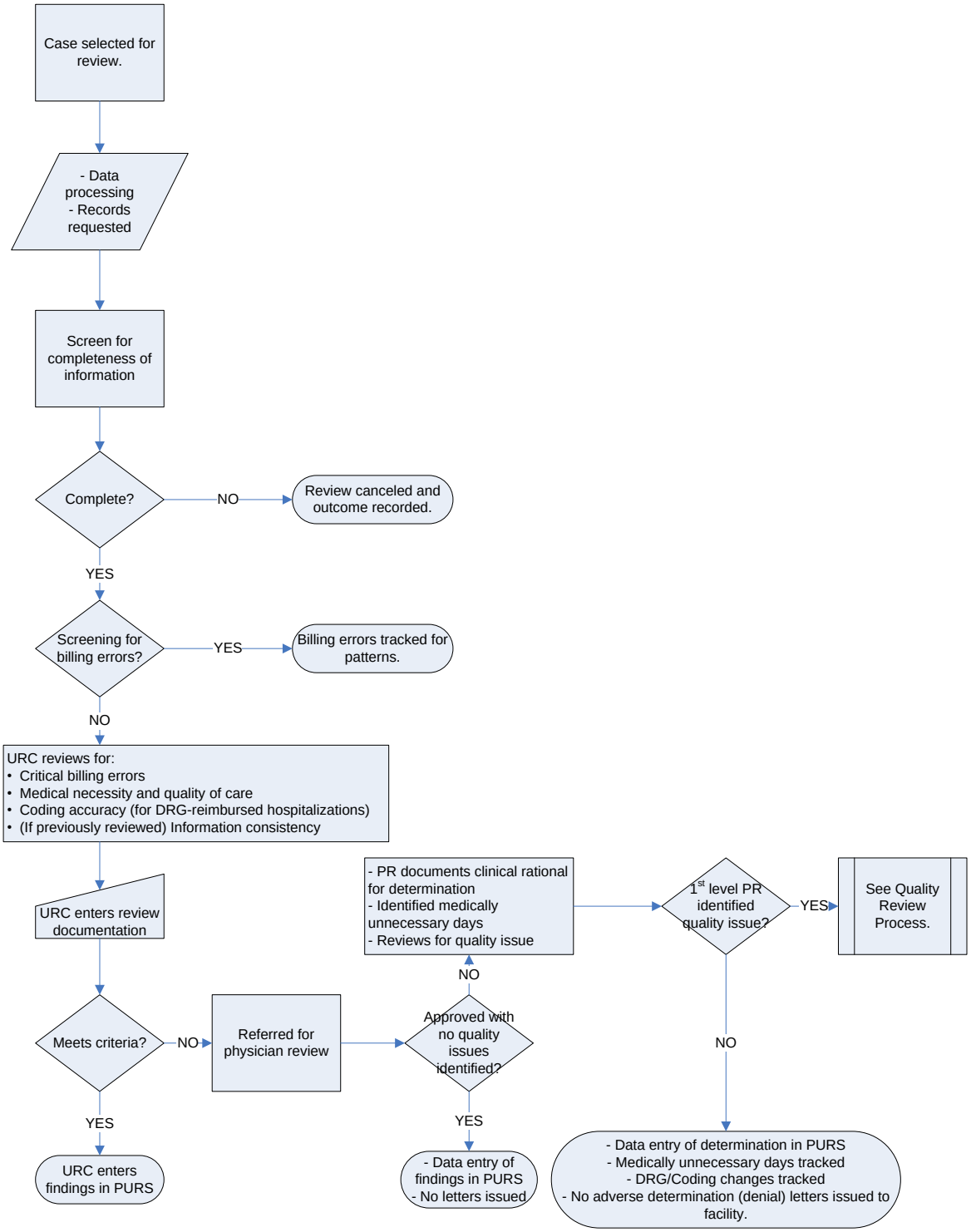
CONCURRENT REVIEW AND QUALITY SCREENING



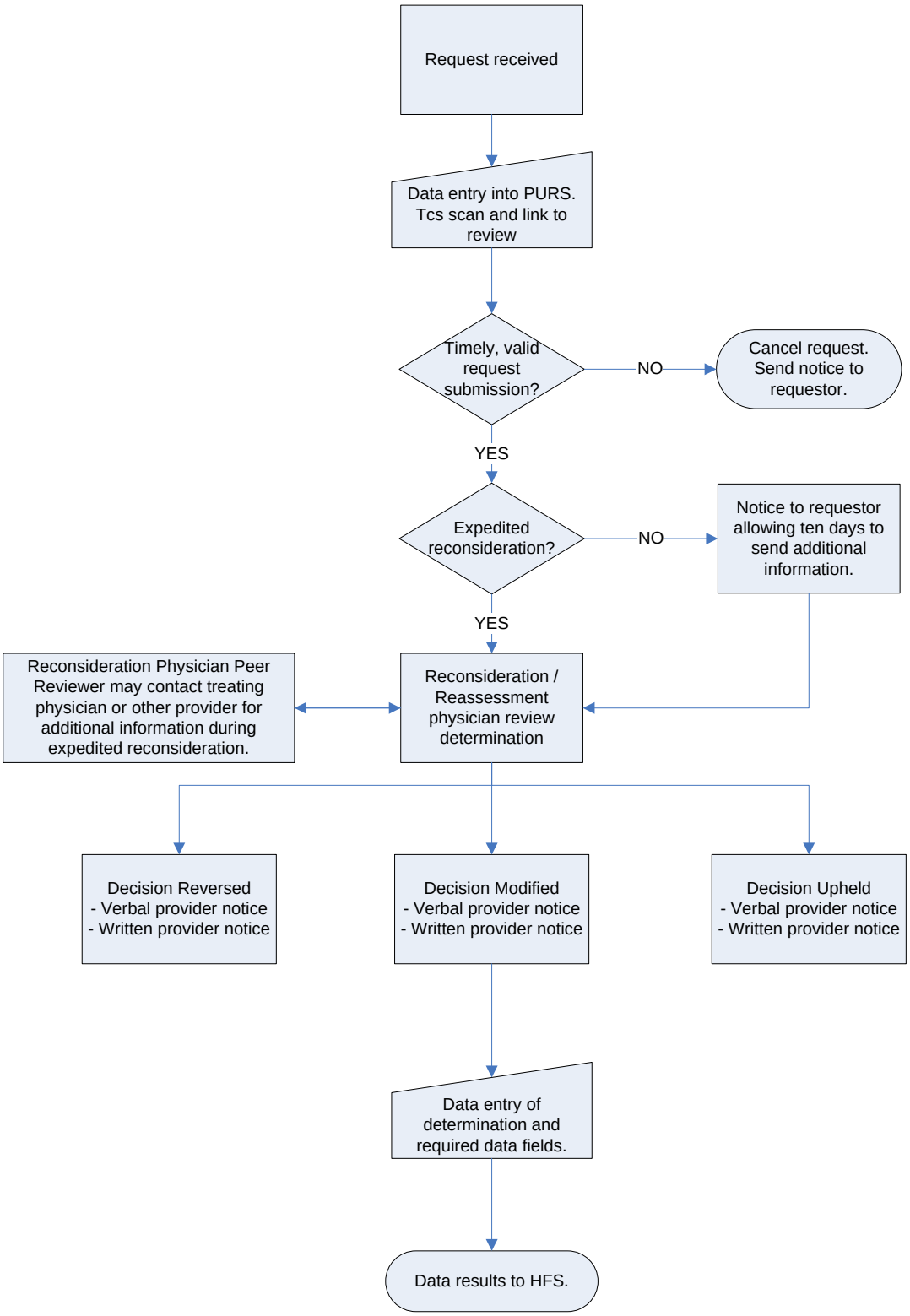
RETROSPECTIVE PREPAYMENT REVIEW PROCESS



RETROSPECTIVE POST-PAYMENT REVIEW PROCESS



RECONSIDERATION PROCESS



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eQHealth Solutions Contact Information

CONTACT LIST:

2050-10 Finley Road Lombard, IL 60148	***Website il.eqhs.org***
Main Lines	
IL Main Number	**630-317-5100**
Business Office Fax	**630-317-5101**
UR Certification Numbers	
LTAC Certification Line	**800-418-3970**
Fax recons, addtl info	**800-418-4039**
Help Line	**800-418-4045**
Office/Email	
Angela Perry, MD	**630-317-5155 (o)**
Medical Director	aperry@eqhs.org
Ava Muckerheide	**630-317-5110 (o)**
Executive Director	amuckerheide@eqhs.org
Isidela Bigol	**630-317-5165 (o)**
Assistant Director of Operations	ibigol@eqhs.org
Jan Balkus	**630-317-5128 (o)**
LTAC Nurse Auditor	jbalkus@eqhs.org
Farah Buric, PhD	**630-317-5104 (o)**
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HR and Facilities Manager	mlund@eqhs.org
Rose Serno	**630-317-5113 (o)**
Prov. Ed. & Outreach Rep.	rserno@eqhs.org
Giovanna DeChiara	**630-317-5185 (o)**
Prov. Ed. & Outreach Coord.	gdechiara@eqhs.org
Charlene Santos	**630-317-5120 (o)**
Executive Assistant	csantos@eqhs.org

eQHealth Solutions Website Homepage

A section of our Web site home page will be dedicated to LTAC providers. This will include HFS' Informational Notice regarding the LTAC Transfer Act Program and a link to the LTAC secure Web Portal. The LTAC Web Portal contains additional information on the program.