



**INPATIENT**  
**Provider Utilization Review and**  
**Quality Assurance Manual**

**Short Term Acute Care**  
**Revised December 15, 2014**



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## Section A: Overview

**Utilization management** is a process that uses an established set of criterion for monitoring and oversight of medical care. At eQHealth Solutions this is achieved by using clinical screening tools to apply consistent, evidence based standards as well as the clinical expertise of skilled utilization review nurses and active practice physician reviewers.

eQHealth Solutions carries out utilization management through the following review types:

### **Precertification Review – Prior Authorization**

Perform medical necessity review of select, planned (non-emergent) procedures for inpatient setting.

### **Concurrent Review**

Perform medical necessity review and determine appropriateness of admission, continued stay/discharge readiness for inpatient setting.

### **Retrospective Review**

Identify critical billing errors and perform medical necessity review and determine appropriateness of admission and ongoing inpatient care. Validate coding.

### **Quality of Care Review**

Using CMS quality of care categories, perform concurrent quality screening and retrospective quality review.

## **Medically Necessary Care**

eQHealth is contracted to perform review of inpatient, fee-for-service Medicaid hospitalizations to determine:

- 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 hospital admissions and discharges.
- Through DRG/APR-DRG validation, the validity of the diagnostic and procedural information supplied by the hospital.
- 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.
- Provider compliance with HFS policies and administrative rules, including a plan to improve quality of care.
- The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of 42 CRF 412.82 and 412.84.

## General Information

### 1. About eQHealth Solutions, Inc.

eQHealth Solutions, Inc. (eQHealth), under contract to Healthcare and Family Services (HFS) since 2002, provides utilization and medical management to evaluate the medical necessity and quality of acute inpatient services for HFS fee-for-service participants.

eQHealth also provides quality of services review, determining the medical necessity, reasonableness and appropriateness of care through Web-based and telephonic interactions. Dedicated to continuous quality improvement, eQHealth offers extensive educational training and outreach for HFS medical program providers to support these activities.

eQHealth Solutions Illinois - Business address	2050-10 Finley Road Lombard, IL 60148
Business telephone ( <i>Monday – Friday, 8 a.m. – 5 p.m.</i> )	(630) 317-5100
Business fax	(630) 317-5101
Certification line ( <i>only approved exceptions to Web submission</i> )	(800) 418-4033
Toll-free fax (reconsideration requests; addtl information only)	(800) 418-4039
Provider Helpline – Log into eQSuite® to Online Helpline ( <i>Monday – Friday, 8 a.m. – 5 p.m.</i> )	<a href="http://il.eqhs.org">http://il.eqhs.org</a> (800) 418-4045
24/7 Website access – Log into eQSuite®	<a href="http://il.eqhs.org">http://il.eqhs.org</a>

### 2. 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. 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 \(MED\) 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 admission certification are 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. Checking if the admitting diagnosis is subject to mandatory concurrent review. Short Term Acute Care hospitals refer to HFS’ Attachments A-C, list of diagnosis codes subject to review for all admission and concurrent stays. Long Term Acute Care hospitals must request certification for all admitting diagnoses.**
- 4. Verifying the participant’s current eligibility and service limits through HFS.**

### 3. Hospital Contacts

Each Provider must submit their hospital-assigned contacts to eQHealth to ensure timely and proper communication. Hospital contacts may be updated any time by completing a Hospital Contact Form, located on our Website at <http://il.eqhs.org>.

#### a. Hospital CEO or 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.

#### b. Hospital Medical Director

The hospital Medical Director information is optional and may be used in targeted communications.

#### c. 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. Only one eQHealth Liaison is permitted per hospital.

#### d. 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.

#### e. 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. The hospital may assign one or two Web Administrators.

### 4. Provider Services and Resources

#### a. Provider Helpline – Online Helpline

An online helpline is available to assist the Provider community. If providers have questions regarding eQHealth Solutions' program requirements, processes or notifications, hospitals may submit inquiries online through our Web-based system. The Provider Helpline is available 8:00 a.m. -5:00 p.m., Monday through Friday, excluding weekends and designated Federal/State holidays.

If a Provider has no Internet access, call the Toll-Free Helpline Number for assistance.

#### b. Provider Education and Training

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

eQHealth Solutions keeps the provider community informed of program changes and updates through communications sent by fax, targeted email exchange and Web site postings.

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> under the Provider Resources tab, including:

- General policy and procedure information in the *Utilization Review 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. **Coding Job Aids for Mandatory Concurrent Review**

eQHealth has created coding job aids which contain the ICD-9-CM admitting diagnosis codes from HFS' Attachments A, B and C that are subject to mandatory concurrent review. Coding job aids are available on our Website, under the Quick Resource section on our homepage.

iii. **Online Access to Perform Utilization Review Tasks**

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

Providers are required to submit all concurrent reviews (admission and continued stay (d/c) reviews) online, as well as requests for Prior Authorization. Our Web-based system eQSuite® is available 24/7. Web review requests will be processed by the URC within four business hours from the time of receipt of all necessary information – excluding weekends and designated Federal and State holidays, which will be completed during the next business day.

eQHealth offers free training sessions to instruct hospitals how to use the Web-based review system and access provider-specific reports. Providers may download the appropriate *guide(s)* from the Provider Resources or PriorAuth Resources tab at <http://il.eqhs.org>.

d. **Provider Outreach**

eQHealth conducts an ongoing Provider Outreach program to educate Providers and engage them as active participants in quality improvement and appropriate utilization of services for the Illinois Medicaid community. This includes monitoring of review standards and Providers' understanding of policies and procedures for utilization review and quality.

We offer the following outreach at no cost to Providers:

- Real-time Reporting – review data is available online 24/7 for Providers to self-audit their utilization activities as well as compare their facility to regional or statewide data.
- Quarterly educational presentations - offered as targeted Provider Outreach and education on varying utilization review topics.
- Notify Providers with atypically high billing errors - eQHealth analyzes review statistics and provides data and education to facilities experiencing high billing errors. These critical billing errors cause the retrospective prepayment review to be cancelled and delay payment.
- Ad-hoc Provider Outreach – as discovered through Helpline inquiries or report of increased issues impacting the hospital's adherence to HFS' utilization management requirements.

## Section B: Inpatient Utilization Review Services

*It is the hospital's responsibility to check for patients' current Medicaid coverage. eQHealth does not perform review for hospitalizations fully covered under Medicare Part A (when days will not exhaust) or under an MCO (Managed Care Organization). If covered under an MCO for the admission, an error message will appear; you may hit "Print Screen" on your keyboard to capture the message for your files. Contact eQHealth if the system message does not comply with your insurance information.*

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### 1. Prior Authorization Review

For Illinois Medicaid fee-for-service participants, prior authorization by eQHealth Solutions is required for elective inpatient Back Surgery and Coronary Artery By-pass Graft (CABG).

Prior authorization review is conducted for select procedures before the patient is hospitalized to assess the medical necessity of the intended procedure. The planned procedure is the purpose for the patient's admission into inpatient care. The procedure(s) subject to Prior Authorization are found on HFS' Attachment F, which became effective with admissions on and after April 1, 2014.

### 2. Mandatory Concurrent Review

Hospitalizations with admissions on or after June 1, 2007, with an admitting diagnosis code on HFS' Attachments A, B or C are subject to mandatory concurrent review or must meet one of HFS' limited exceptions (as defined below). The provider will submit an electronic or paper claim for these hospitalizations. *Mandatory concurrent review only applies to Illinois hospitals and out-of-state hospitals in counties contiguous to Illinois.* HFS will allow limited 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 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.

*eQHealth Solutions determines whether certification review is required based on the admitting diagnosis code and the inpatient medical coverage/benefits outlined by HFS' medical program for the inpatient admit date. The admitting diagnosis code submitted to eQHealth is used to determine whether review is necessary for a covered HFS participant. Codes subject to review are included on HFS Attachment List A-C. Please note that Long Term Acute Care (LTAC) facilities must request certification for all admitting diagnoses.*

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Admission/Concurrent review applies to both DRG/APR-DRG -reimbursed and Per Diem- reimbursed hospitalizations. The codes subject to review may be revised periodically and HFS notifies hospitals thirty calendar days prior to their implementation. However, HFS will not send a notice to hospitals when the ICD-9-CM coding guidelines mandate a coding change requiring a 4<sup>th</sup> or 5<sup>th</sup> digit code extension on codes currently subject to review.

Along with the determination of medical necessity, reasonableness and appropriateness of acute inpatient care, **quality screening also takes place during concurrent review**. As part of the concurrent review process, nurse reviewers (URCs) will *screen* for potential quality issues based on the clinical information provided by the hospital. If a potential quality concern is identified, the URC will refer the information to a Physician Peer Reviewer (PR). If the information suggests there is, or may be immediate and significant risk to the patient, the PR will contact the treating physician to discuss the situation. 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.

#### **DRG and Per Diem Reimbursed Hospitalizations**

Hospitals must obtain certification of the admission, and HFS requires the hospital to contact eQHealth at the time of discharge for a quality of care screening and provide the discharge date.

#### **a. Types of Mandatory Concurrent Review**

##### ***i. 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. Hospitalizations with an admitting diagnosis code on HFS' Attachments A, B or C are subject to mandatory concurrent review. The only time a concurrent review may be performed after discharge is for "short stay" hospitalizations of three days or less. Short stays with an admitting diagnosis on HFS' Attachments A, B or C must be reviewed within seven days of the discharge date (for more information about short stays, see subsection iii. Short Stay Review on the following page). *The admission review process applies to both Per Diem and DRG-reimbursed hospitalizations.*

##### **Inpatient Detoxification Admissions**

Effective with admissions on or after July 9, 2012, HFS implemented a 60-day readmission policy for all inpatient detoxification admissions.

Certification should be requested within 24 hours of inpatient admission, after verification that the patient is eligible for inpatient detoxification services. The short-stay, post-discharge policy does NOT apply to inpatient detoxification services.

Providers can access inpatient eligibility online, 24/7 using the eQHealth *Detox Eligibility Look Up* utility. Admission requests are submitted within 24 hours of inpatient admission and while the patient is still hospitalized. All detoxification admissions must be submitted via eQSuite® within 24 hours of admission. *If staff is not able to submit weekend admissions, these detox admissions may be submitted via Web on Monday morning ONLY if the participant remains hospitalized.*

## ii. **Continued Stay Review (DRG Discharge Review)**

To facilitate the continued stay review process, eQHealth Solutions sends the hospital a daily report that lists all open cases. The Per Diem (P) reimbursed hospitalization certifications expire within one day and require either a continued stay review or the discharge date. The DRG (D) reimbursed hospitalizations on this list require a quality of care (cont. stay) review at the time of discharge.

### Per Diem Reimbursed Hospitalizations – Continued Stay Requests

If the number of medically necessary hospital days exceeds the number certified on the last review, the hospital will request certification for the continued stay one day prior or the last day certified

### DRG/APR-DRG Reimbursed Hospitalizations – Continued Stay Requests

DRG and APR-DRG reimbursed hospitalizations require a quality of care screening (cont. stay review) at the time of discharge and record the discharge date.

- **DRG/APR-DRG 1 day stays:** Simply record the discharge date by using the Utilities tab in eQSuite®, a review is not required for 1 day stays.

## iii. **Short Stay Review**

For admissions involving short stays of three days or less, post-discharge, hospitals may submit admission review requests online within seven calendar days of discharge. Providers will include the discharge date in the admission review. This short-stay policy **does not** apply to detoxification admissions.

*If the admission was certified by eQHealth Solutions, the hospital may still request a continued stay review (or discharge review) if the claim for services has not been submitted. Hospitals must adhere to HFS' 180-day claims submission requirement.*

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## b. **Methods of Submission for Concurrent Review**

Requests for admission and continued stay review (including DRG discharge reviews) must be submitted to eQHealth Solutions through their Web-based system, eQSuite®:

eQSuite® affords hospitals the following benefits of using an online platform:

- Ability to complete all review functions online 24/7
- Hospital-assigned Web Administrator creates and maintains preferred users
- Secure transmission protocols that are HIPAA security compliant
- Directly connected to HFS' database for immediate verification of eligibility
- Copy and paste from electronic records
- View and print notifications on demand
- Flexibility for users to share review tasks
- Provider specific Web reports with real-time and historic review data

Our Web-based system eQSuite® is available, 24 hours a day 7 days a week at <http://il.eqhs.org>. Web review requests will be processed by the URC (nurse) within four *business* hours from the time of receipt of all necessary information – excluding weekends and designated Federal and State holidays. These requests will be processed the next business day.

Providers granted as HFS exceptions include critical access and out-of-state hospitals.

### c. Recording Discharge Dates

A daily list titled *Medicaid Cases Due for Concurrent Review* is faxed to the eQHealth Liaison each day. This list contains hospitalizations for HFS participants requiring concurrent review and/or a discharge date. It designates if the Payment Type (PM) is either P (Per Diem) or D (DRG).

**This list is no longer faxed back to eQHealth Solutions to record discharge dates.** Effective November 2014, Providers must record the discharge date and complete the review process online through eQSuite®, based on the reimbursement type of hospitalization:

#### Recording Discharges for Per Diem Reimbursed Hospitalizations

The hospital will submit the discharge date online through eQSuite® when:

- The number of medically necessary hospital days are certified to cover the hospitalization; **OR**
- After the hospital submits a reconsideration request for denied days and there is a final determination of the number of days certified and days denied.

#### Recording Discharges DRG Reimbursed Hospitalizations

DRG reimbursed hospitalizations require a quality of care screening (cont. stay review) at the time of discharge. Providers will create a new review in eQSuite® and record the discharge date as part of this review.

- **1 day stays:** Simply record the discharge date by using the Utilities tab in eQSuite®, a review is not required for 1 day stays.

### d. Review Process

eQHealth Solutions conducts utilization review using Utilization Review Coordinators (URCs) and Physician Peer Reviewers (PRs).

#### ***i. Utilization Review Coordinator (URC) Review Process and Outcomes***

URCs are registered nurses who receive the hospitals' review requests by Web or phone. They apply HFS-approved medical or behavioral health criteria to determine medical necessity for admission or continued stay. If the criteria are satisfied such that admission or continued stay request can be certified by the URC, the Length of Stay (LOS) benchmarks are used as a guide to assign the length of stay and the next review point. Based on the information submitted by the Provider, URC outcomes include:

- Approve – certification of admission or continued stay days
- Pend – pend the request for additional information to help support criteria
- Refer – refer the case to a Physician Reviewer (PR) if criteria cannot be satisfied

The eQHealth Liaison receives written notification that a Physician 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.

#### ***ii. Physician Review Process and Outcomes***

The physician review is based on medical judgment and nationally recognized, appropriate clinical care standards. All efforts are made to match the care being reviewed to a physician of the same specialty. The PR may approve the care and assign the length of stay based on information submitted by the Provider. Only an eQHealth Solutions Physician Peer Reviewer (PR) 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.

Pre-operative Day(s): If a medical necessity denial is rendered by a PR for one or more pre-operative day(s), payment for that care will not be made by HFS. A notice of determination will be issued informing the hospital and attending physician of the denial.

Admission Medical Necessity: If non-certification (denial) is rendered by a PR because the hospitalization is determined not to be medically necessary, payment for that care will not be made by HFS. A notice of determination will be issued to the hospital and attending physician.

Concurrent/Continued Stay Medical Necessity: If it was determined that continued acute inpatient care is not medically necessary by a PR, payment will not be made by HFS. A notice of determination will be issued informing the hospital and attending physician of the denial.

**e. Concurrent Review Time Frames**

Utilization Review Coordinator (URC) Certifications

URC (nurse) determination is rendered within four business hours from the 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. A notice of determination is issued to the eQHealth Liaison and available online through eQSuite®.

Physician Peer Reviewer (PR) Referrals and Determinations

If a case is referred for physician review, a *Physician Peer Reviewer (PR) Referral Notice* is automatically sent to the hospital eQHealth Liaison and can be accessed on eQSuite®. For admission and continued stay reviews, PR determinations are rendered within one business day after the review is sent for physician review.

If there is a medical necessity non-certification (denial), the treating physician is notified verbally at the time of the peer-to-peer discussion. Written notice of the adverse determination is mailed to both the attending physician and the hospital's eQHealth Liaison and is available online through eQSuite®.

**f. Children's Mental Health**

**i. Children's Mental Health Act of 2003/ SASS**

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

**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/](http://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.

*CARES and eQHealth are separate entities. eQHealth cannot proceed with review until CARES records their involvement in the admission. As contracted by HFS, eQHealth begins review after the first date of CARES involvement. Contact CARES at (800) 345-9049.*



**g. Long Term Acute Care**

The Long Term Acute Care Hospital Quality Improvement Transfer Program Act of 2010 (Public Act 096-1130) represented an opportunity for collaboration among state agencies to conduct utilization and quality review on all Medicaid beneficiaries admitted to a Long Term Acute Care (LTAC) facility.

As a provision of Public Act 096-1130, HFS required review of all LTAC hospitalizations as of October 1, 2010. The eQHealth standard review process is also followed for LTAC hospitalizations. All LTAC admissions are subject to mandatory concurrent review.

*It is important for hospitals to include the treating physician's contact information as part of the review (if treating physician differs than the attending or there is an alternate phone number). Notification letters for certification, additional information or denial are summarized in Section 4.*

*When billing HFS for certified acute inpatient care, the hospital must report the same admitting diagnosis code and inpatient admission date submitted to eQHealth Solutions on the UB-92/UB-04 claim form or 837I electronic claim submittal.*

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REVIEW REQUIREMENTS FOR PRIOR AUTHORIZATION, ADMISSION AND CONCURRENT REVIEW				
Description	Review Type	Inpatient Service	HFS Attachments Subject to Review	Submission Timeframe
<b>Prior Authorization Review</b>				
Prior Authorization of Elective Procedure (inpatient, non-emergent)	Prior Authorization (Admission)	Med/Surg	Attachment F	Submit up to 30 days prior or a minimum of 3 business days prior to the admission date.
<b>Short Stay Review</b>				
Short Stay Hospitalization of 3 days or less; post discharge	Short Stay	Med/Surg Psychiatric (no Detox)	Attachment A-C	Submit no later than 7 calendar days after discharge.
<b>Admission Review</b>				
Admission Inpatient Hospitalization	Admission	Med/Surg Psychiatric	Attachment A-C (All diagnoses are subject to review for LTACs)	Submit within 24 hours of admission; while patient is still in inpatient care.
Detox Admission Inpatient Hospitalization	Admission	Detoxification Med/Surg Psychiatric	Detoxification Codes HFS Attachment B	Use Detox LookUp utility to determine inpatient eligibility.  Submit within 1 day after inpatient admission.
<b>Continued Stay Review</b>				
Per Diem Reimbursed Continued Stay Inpatient	Continued Stay	Med/Surg Psychiatric	Attachment A-C	Submit request 1 day prior to the last day certified or the last day certified.
DRG Reimbursed Discharge Review Inpatient	Continued Stay	Med/Surg Psychiatric 3 day emergency care	Attachment A-C	Submit within 24-48 hours of discharge for hospitalizations greater than 1 day.

## 2. Retrospective Review

eQHealth Solutions is also contracted by the Illinois Department of Healthcare and Family Services (HFS) to perform retrospective prepayment and post-payment review. Retrospective review is a full scope review which requires a copy of the HFS participant's complete medical record. During retrospective review, the medical necessity of the admission, each day of care (including DRG and APR-DRG reimbursed hospitalizations) and the appropriateness of invasive procedures are reviewed. In addition, eQHealth Solutions conducts quality of care review, validates the accuracy of billed ICD-9-CM and DRG/APR-DRG codes, and monitors for critical billing errors.

### a. Types of Retrospective Review

#### i. *Retrospective Prepayment Review – DRG and APR-DRG-Reimbursed Care*

All claims submitted to HFS for acute inpatient services with an admitting diagnosis code on HFS' Attachment D will be selected for prepayment review. Admissions with an admitting diagnosis on HFS' Attachments A, B or C may also be selected for prepayment review:

- If a paper claim is sent and meets HFS exceptions to Mandatory Concurrent Review
- *For out-of-state hospitals* if the admission was not certified concurrently

HFS selects cases for hospitalizations subject to retrospective prepayment review and provides eQHealth Solutions with a list of these cases each week. These hospitalizations are selected from claims submitted to HFS. Prepayment review is conducted offsite at eQHealth Solutions. Hospitals are afforded 14 calendar days from the date of *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts to eQHealth Solutions' office for review. Under HFS contract, the time frame for a Retrospective Prepayment review to be completed is 44 calendar days from the date of Notice (30 days after the 14 day window to receive medical records).

First, a Utilization Review Coordinator (URC) checks for critical billing errors. If critical billing errors are identified the review is cancelled and notification is sent to the hospital Liaison. The hospital must remedy the billing error and re-submit their claim to HFS, when appropriate.

All care subject to review is initially completed by a Utilization Review Coordinator (URC) who applies the appropriate clinical criteria and quality screens to determine medical necessity of the hospitalization and to assess the quality of care. Additionally, coding validation is completed for all principal and secondary diagnosis and procedure codes. Based on the information submitted by the Provider, URC outcomes include:

- Approve – certification of admission or continued stay days
- Pend – pend the request for additional information to help support criteria
- Refer – refer the case to a Physician Reviewer (PR) if criteria cannot be satisfied

The eQHealth Liaison receives written notification that a Physician 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.

#### *Retrospective Prepayment Review for Cesarean Section*

As part of Illinois' Public Act 097-0689, Save Medicaid Access and Resources Together (SMART Act) and a growing national effort to reduce preterm births resulting from elective deliveries, Healthcare and Family Services (HFS) added APR-DRG Code 540 – Cesarean Delivery to their Attachment D list of codes subject to retrospective Prepayment review.

*During prepayment review of a Cesarean Section, coding and validation of diagnosis and procedure codes is not performed.*

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The Cesarean Section prepayment review will be limited to:

- a) Identifying that the C-section procedure was medically necessary – Applying *InterQual 2012* criteria and using *American Congress of Obstetrics and Gynecology (ACOG) nationally-recognized guidelines*
- b) Ensuring quality of care - Applying Centers for Medicare & Medicaid (CMS) *Quality of Care Review Category screens*

**ii. Retrospective Prepayment Review - Per Diem Reimbursed Care**

Claims submitted to HFS for acute inpatient services (Per Diem Reimbursed) may be selected for retrospective prepayment review and approval prior to HFS rendering payment when the:

1. Admitting diagnosis code is on HFS' Attachments A, B or C, and
2. Admission was not certified through the concurrent review process and meets one of HFS' exceptions to mandatory concurrent review.

HFS provides eQHealth Solutions with a list of selected cases for hospitalizations subject to retrospective prepayment review from claims submitted to HFS. Prepayment review is conducted at eQHealth Solutions and hospitals are afforded 14 calendar days from the date on the *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts by mail for review. Under HFS contract, eQHealth is afforded 44 calendar days from the date of the Notice to complete Retrospective Prepayment review (30 days after the 14 day window to receive medical records).

First, a Utilization Review Coordinator (URC) checks for critical billing errors. If critical billing errors are identified the review is cancelled and notification is sent to the hospital Liaison. The hospital must remedy the billing error and re-submit their claim to HFS, when appropriate.

All care subject to review is initially completed by a Utilization Review Coordinator (URC) who, using the medical record from the hospital, applies the appropriate clinical criteria and quality screens to determine medical necessity of hospitalization and to assess the quality of care. Additionally, coding validation is completed for all principal and secondary diagnoses and procedure codes. See Section C below for the review outcomes.

**iii. Retrospective Post-payment Review**

Post-payment review is conducted for a sample of stays following reimbursement to the hospital for the care provided. As instructed by HFS, sample of hospitalizations for post-payment review is selected by eQHealth Solutions from paid claims data. Post-payment review does not influence payment as does prepayment review. The number of records selected will vary based on the hospital's volume of HFS participant admissions, its case mix and admitting diagnoses.

Post-payment review is conducted offsite at eQHealth Solutions and includes review of the medical necessity of the hospitalization, each day of care (including DRG and APR-DRG -reimbursed hospitalizations) 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 the accuracy of billed ICD-9-CM and DRG/APR-DRG codes, and monitors for critical billing errors. For post-payment review, hospitals are afforded 14 calendar days from the date on the *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts to eQHealth's office for review.

**b. Method of Submission for Retrospective Review**

All retrospective prepayment and post-payment reviews are performed at eQHealth Solutions. Each hospital is sent a notification of those cases which HFS has selected for review. The notification is faxed to the eQHealth 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 case, complete and attach the tracking sheet, and securely ship the records to eQHealth Solutions within 14 calendar days from the date of notice. Hospitals will be reimbursed by eQHealth at 10 cents per page or 20 cents for double sided copying costs.

**c. Retrospective Review Outcomes**

***i. Review Determinations Resulting from Retrospective Prepayment Review***

Two types of outcomes may occur from retrospective prepayment review. The URC may:

- Certify the hospitalization – no critical billing errors found, medical necessity criteria has been met, quality screens did not fail and the payment group/coding validated; or
- Refer the record to a Physician Peer Reviewer (PR) for one or more of the following - medical necessity criteria was not met, quality screen(s) failed, payment group/ coding was not validated (where applicable).

Adverse Determinations for Retrospective Prepayment Review

Prior to rendering an adverse determination, the PR will make one attempt to discuss the case with the treating physician. The following types of adverse determinations may be rendered:

- Medical Necessity: If a non-certification (denial) is rendered by a PR because the admission was determined not to be medically necessary, payment for that care will be denied by HFS. Written notice will be issued informing the hospital and physician of the non-certification determination.
- Pre-operative Days: If an adverse determination involves non-certification (denial) by a PR of one or more pre-operative days, payment for that care will be denied by HFS. Denials of any or all pre-operative days will result in the need to re-bill the care to HFS and attach the non-certification of days notice. Written notice is issued informing the hospital and attending physician of the determination
- Invasive Procedures: If it is determined that one or more invasive procedure(s) were not reasonable, medically necessary, or did not meet professionally recognized standards of care, the procedure will not be certified (denied) by the PR. If the case is DRG /APR-DRG -reimbursed, the procedure will be removed from the DRG/APR-DRG. If the sole reason for admission was for performance of the denied procedure, the hospitalization will not be certified (denied). Non-certification of any invasive procedure will result in the need to re-bill the care to HFS and attach the denial notice. Written notice is issued to the hospital Liaison and attending physician.
- Inappropriate Coding: If an adverse determination involves inaccurate or inappropriate coding, it is necessary to re-bill HFS for the care only if the revised coding results in a change in the payment group. This information will be documented on the *Notice of Payment Group Change* issued to the hospital eQHealth Liaison. It is necessary to attach this notice to re-bills.

***ii. Review Determinations Resulting from Retrospective Post-payment Review***

The URC will confirm the certification of admission and that quality screens were not failed and also look at invasive procedures, validate ICD-9-CM billing and DRG and APR-DRG coding as well as screen for critical billing errors. Since this process is post-payment, it does not affect hospital payment; however, any utilization, quality or coding concerns are referred to a Physician Reviewer and reported in summary to HFS.

## Section C: Reconsideration and Reassessment

A hospital or physician who disagrees with a non-certification (denial) determination from eQHealth's Physician Peer Reviewer (PR) has the right to request a reconsideration and to present additional evidence in support of the medical necessity of the stay. In each case where eQHealth Solutions reaches a decision which affects the certification of the hospitalization, the hospital and the attending physician are sent a notice. This notice will also advise them of the procedures to follow to request a reconsideration or a reassessment. eQHealth's reconsideration form and instructions may be downloaded from <http://il.eqhs.org>, under Provider Resources.

### a. **Standard Reconsideration**

A standard reconsideration is available for denials rendered by a physician reviewer during admission, concurrent or retrospective review. The hospital or physician may submit a request by completing a Reconsideration Request Form, accompanied by additional clinical information to support the medical necessity of the date(s) denied. This request must be received by eQHealth within 60 calendar days of the *Notice of Denial*. This can be sent to eQHealth via fax, mail or preferred carrier.

eQHealth Solutions is allotted 30 calendar days to render a determination after the receipt of all valid, necessary information for the reconsideration.

### b. **Expedited Reconsideration**

An expedited reconsideration is only available for hospitalizations reviewed through the concurrent review method and must be received by eQHealth Solutions while the patient is still hospitalized. This is beneficial if pertinent information fully supporting the medical necessity of the denied day(s) was originally omitted from the review request, otherwise a standard reconsideration would be in order. The hospital or physician may submit a request by completing a *Reconsideration Request Form*, accompanied by additional clinical information to support the medical necessity of the date(s) denied. This can be sent to eQHealth via fax or preferred carrier.

For expedited reconsiderations, a determination by a Physician Peer Reviewer (PR) is made within three business days of the receipt of all valid, necessary information.

#### ***i. Expedited Reconsideration - Prior Authorization***

The hospital or physician may send a request for expedited reconsideration. The request must be received within 10 business days of the denial notice and prior to the admission. Submit the ***Prior Authorization Reconsideration Request form*** to eQHealth with any supporting information via facsimile or other acceptable means.

A determination by a second, Physician Peer Review (PR) is made within three business days of the receipt of all valid, necessary information.

### c. **Reassessment**

A reassessment may be requested after a PR determines that the billed principal diagnosis, secondary diagnoses, and/or procedural coding is inconsistent with the documentation in the medical record and has resulted in revision of the payment group.

A notice is sent to the hospital eQHealth Liaison and attending physician and a reassessment may be requested in writing to eQHealth Solutions within 60 calendar days of the notification. When a request for reassessment is received, an *Acknowledgement of the Receipt of Request for Reassessment* will be sent to the eQHealth Liaison and the attending physician. eQHealth Solutions is allotted 30 calendar days to render a determination after the receipt of all valid, necessary information for the reassessment.

## Section D: Provider Notifications

*All Provider notifications (letters) for admission/concurrent review are available online through eQSuite®. Click on the Letters tab online to view or print-on-demand.*

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### a. Prior Authorization Review Notifications

**Notice of Review Approval** – This notice is issued to the eQHealth Liaison when a request for the Prior Authorization of an elective procedure on HFS Attachment F is certified by the Utilization Review Coordinator (URC) or the Physician Peer Reviewer (PR).

**Notice of Denial – Certification Request** – This denial notice is issued to the eQHealth Liaison when based on available clinical information, the PR was unable to certify the medical necessity of the procedure.

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

**Notice of Invalid Request for Reconsideration** – This notice is issued 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 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.
- Reversed - Original denial is completely reversed and the Prior Authorization is certified as medically necessary. The services must be re-billed with a copy of the notice attached.

### b. Admission/Concurrent Review Notifications

**Notice of Review Approval** – This notice is issued to the 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).

Notice of Review Approval – (Per Diem Reimbursed Hospitalizations)

The *Notice of Review Approval* 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 Review Approval – (DRG-Reimbursed Hospitalizations)

The *Notice of Review Approval* informs the hospital of the certification, the admit diagnosis code used during the admission certification process, the treatment authorization number (TAN), and the notice to contact eQHealth Solutions for a quality of care screening at the time of discharge with the discharge date. Since this is not a length of stay review, the eQHealth *Notice of Review Approval* for DRG reimbursed hospitalizations does not show days certified (the admission is certified and is signified with “1” on Provider reports).

*If a participant is non-eligible, a pop-up message will appear on eQSuite® stating there is an error. The user will click on the Error tab on left of screen to display the message. The requestor may click “Print Screen” to keep a copy for their files. Since the request is null, a notice is not generated.*

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

**Physician Peer Reviewer (PR) Referral Notice** – This notice is issued to inform the 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 eQHealth Liaison when, based on available clinical information, the PR was unable to certify the medical necessity of the admission or continued stay.

**Notice of Denial – Pre-operative Day(s)** – This denial notice is issued to the eQHealth Liaison when, based on available clinical information, the PR was unable to certify one (1) or more pre-operative day(s) due to lack of medical necessity. However, the hospitalization is certified and the hospital receives a separate *Notice of Review Approval*.

### c. Retrospective Review Notifications

*Copies of medical records should not be submitted to HFS or erroneously sent to eQHealth for review. Medical records will only be sent to eQHealth by request. When HFS selects cases for prepayment review or cases are selected for post-payment review, eQHealth will send a Notice of Selection of Medical Records for Offsite Review to the hospital Liaison. A copy of these notices are available as Reports 41 and 42 on eQSuite®*

**Notice of Selection of Medical Records for Offsite Review** – This notice accompanies a listing of cases selected for off-site review and is faxed to the 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. If sending multiple records, please band each record separately.**

**Notice of Cancelled Review – Prepayment Review** – This notice is issued to the eQHealth Liaison when a case has been selected for prepayment review but the chart is not available for nurse (URC) or physician review. The claim must be resubmitted to HFS when the chart becomes available for review. 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.

**Notice of Incorrect Billing – Prepayment Review** – This notice is issued to the eQHealth Liaison when care has been billed incorrectly and cannot be reviewed (excluding Cesarean Section review). Common incorrect billing examples include incorrect Category of Service (COS) 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 an incorrect discharge status, admission and/or discharge dates result in the billing of an incorrect length of stay.

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

**Notice of Payment Group Change** – This notice is issued following coding validation and PR determination that the billed principal diagnosis, secondary diagnoses, and/or procedural coding is inconsistent with the documentation in the medical record and has resulted in revision of the DRG assignment. The DRG change will alter the hospital's reimbursement; therefore, the care must be re-billed to HFS with the notice attached.

**Notice of Payment Group Change** – This notice is issued following coding validation and PR determination that the billed principal diagnosis, secondary diagnoses, and/or procedural coding is inconsistent with the documentation in the medical record and has resulted in revision of the APR-DRG assignment. The APR-DRG change will alter the hospital's reimbursement; therefore, the care must be re-billed to HFS with the notice attached.

**Notice of Review Approval – Prepayment Review**

**Notice of Approval – Cesarean Section Procedure**

These notices are issued to the 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).

**Notice of Admission Denial– Prepayment Review** – This notice is issued 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 Preoperative Day(s) Denial – Prepayment Review** – This notice is issued when a PR is unable to substantiate the medical necessity of the one or more preoperative days. Payment for the denied portion of the stay is denied by HFS.

**Notice of Length of Stay Denial** – This notice is issued 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.

**Notice of Denial – Prepayment Review: Cesarean Section Procedure** – 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 the cesarean section procedure. The notice states that HFS may reimburse the hospitalization as a vaginal delivery.

Reconsideration of a non-certification (denial) determination may be 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.***

d. **Reconsideration Notifications**

**Notice of Reconsideration Determination – Reversed or Notice of Reconsideration Determination (Modified or Upheld)** – This notice is issued to inform the 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. The services must be re-billed with the Notice attached.

**Notice of Invalid Request for Reconsideration** – This notice is issued when a request for reconsideration exceeds the allowed 60 day timeframe for submitting the request.

**Acknowledgement of Receipt of Request for Reconsideration** – This notice is issued to the eQHealth Liaison and 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.

**Notice of Invalid Request for Reassessment a Payment Group Change** – This notice is issued when a request for Reassessment exceeds the allowed 60 day timeframe for submitting the request or does not include required documentation.

**Acknowledgement of Receipt of Request for Reassessment** – This notice is issued to the eQHealth Liaison and attending physician to acknowledge receipt of a request for reassessment. The hospital and the attending physician are afforded 10 days to submit additional information to be considered.

**Notice of Reassessment (Re-review)** – This notice is issued to inform the hospital eQHealth Liaison and attending physician of the outcome of the reassessment review. The original payment group change may be:

- Upheld - Original payment group change is upheld.
- Modified - Original payment group change determination has been modified to reflect a revision of the diagnostic code(s) but not a total reversal of the original determination. To receive the correct reimbursement, the care must be re-billed to HFS with the notice attached.
- Reversed - Original payment group change determination is completely reversed.

*After the reconsideration and final determination has been made, the care must be re-billed to HFS with a copy of the Notice attached to receive the correct reimbursement.*

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## Section E: 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. It is the policy of eQHealth Solutions, Inc. (eQHealth) to perform quality of care review to determine the completeness, adequacy and quality of hospital care provided, in accordance with Centers for Medicare and Medicaid Services (CMS) 42 CFR, Part 476.

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 through quality improvement plans.

Retrospective quality of care review is conducted only when access is available to the complete medical chart through retrospective prepayment or post-payment review. Nurse reviewers apply the Centers for Medicare & Medicaid Services (CMS) quality of care concern categories and, if a potential quality of care concern is identified, it is referred to a Physician Peer Reviewer (PR) for review. A quality of care issue is only confirmed after a full chart review by a PR is completed and the provider has been afforded an opportunity to discuss or submit additional information. Serious quality of care issues are reviewed by a Physician Review Panel consisting of at least three board-certified physicians.

- A Physician Peer Reviewer (PR) reviews the available clinical information, applying his or her clinical knowledge, experience, judgment and professionally recognized standards of care to render a quality determination.

#### a. Quality Notifications and Timelines

If the issue involves hospital departments only, a letter is mailed to eQHealth's Liaison.

If the issue involves any physicians, or both physicians and the hospital, letters are mailed to both the hospital eQHealth Liaison and any cited physicians.

- The hospital has 20 calendar days in which to submit additional information for an eQHealth Physician Reviewer (PR) to review the case.

After 20 calendar days, the case is returned to the original PR (with additional information when provided) for confirmation, downgrading, or resolution of the quality issue based on the information provided and then one of the following notifications is sent:

- If all quality issues are resolved or downgraded, a notification of a non-confirmed quality issue is mailed. If the quality issue(s) is confirmed, a Provider notice of a confirmed quality issue is mailed, indicating that the issue(s) will be forwarded to the Panel.

The cited party(ies) will be allowed 15 calendar days to submit additional information and/or request peer to peer discussion with the Panel.

#### b. Quality Improvement Plan and Reporting and Monitoring

##### Quality Improvement Plan

A Quality Improvement Plan (QIP) is requested from the cited party(ies) when an inappropriate pattern of utilization, a single serious quality issue, or a pattern of moderately serious quality issues is identified. eQHealth monitors the effectiveness of the quality improvement plan that is implemented.

### **Reporting and Monitoring**

As required by contract with the Illinois Department of Healthcare and Family Services (HFS), eQHealth Solutions is required to notify HFS of all potential serious quality issues identified by a Physician Peer

Reviewer. In addition, upon approval of the hospital's submitted quality improvement plan by Physician 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. 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 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 Physician Peer Reviewer reviewed the case a second time with 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 was non-confirmed.

**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.