Inpatient Services

eQHealth Solutions Provider Manual

2020

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About AHCA

The Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA or Agency) was statutorily created by Chapter 20, Florida Statutes. The Agency champions accessible, affordable, quality health care for all Floridians. It is the state's chief health policy and planning entity. AHCA is the single state agency responsible for administering Florida's Medicaid program which currently serves over 2.8 million Floridians. As such, it develops and carries out policies related to the Medicaid program. The Medicaid program is administered by the Agency's Division of Medicaid Services.

AHCA's Mission

AHCA's mission is Better Health Care for All Floridians.

About eQHealth Solutions

Company Information, Mission, Vision and Values

eQHealth Solutions is a non-profit, multi-state health care quality improvement, medical cost management and health information technology company providing a wide range of effective and efficient solutions for our clients. Services include care coordination, utilization review, quality improvement, wellness services and quality review for home and community-based waiver services. eQHealth Solutions is a leader in assisting providers to embrace health information technology (HIT) to improve the quality of care provided to patients / recipients.

Corporate Mission

"Improve the quality and value of health care by using information and collaborative relationships to enable change"

Corporate Vision

"To be an effective leader in improving the quality and value of health care in diverse and global markets"

Corporate Values

- *Pursuit of innovation;*
- *Integrity in the work we do;*
- *Sharing the responsibility for achieving corporate goals;*
- *Treating people with respect;*
- *Delivering products and services that are valuable to customer;*
- *Fostering an environment of professional growth and fulfillment;*
- *Engaging in work that is socially relevant; and*
- *Continuous quality improvement.*

eQHealth Solutions Locations and Clients

Florida

eQHealth Solutions was awarded the contract in 2011 by Florida's Agency for Health Care Administration (AHCA or Agency) to serve as its Medicaid Quality Improvement Organization (QIO). On behalf of the Agency, our Florida location provides diverse medical cost and quality management services in a variety of inpatient and non-inpatient settings. Our main office is located in the Tampa Bay area.

Louisiana

Under a federal contract with the Center for Medicare and Medicaid Services (CMS) since 1986-2014, our office in Louisiana serves as the state's Medicare QIO. As the Louisiana QIO, eQHealth Solutions assisted providers in achieving significant improvements quality of care in areas such as heart attack and pneumonia care, nursing home quality, home care delivery, prevention and wellness and adoption of electronic health records. Starting in 2014 as a QIO-Like entity, we provide quality improvement field – based work as a subcontractor to a regional Medicare QIN-QIO.

In 2009, we began our Senior Medicare Patrol grant with the federal Administration for Community Living (formerly AoA) to develop and implement anti-fraud efforts in Louisiana with additional awards covering the sates of Florida and Mississippi. This work is supported through our QIO infrastructure.

Mississippi

Under contract with the State of Mississippi's Division of Medicaid (DOM) since 1997, eQHealth Solutions serves as the utilization management and QIO to provide health care quality and utilization management services in a variety of inpatient and non-inpatient settings. We also perform All Patient Refined-Diagnosis Related Group validation review.

Illinois

Under contract with the Illinois Department of Healthcare and Family Services (HFS), since 2002, eQHealth Solutions serves as the Medicaid QIO, providing acute inpatient quality of care and utilization management, DRG and APR-DRG validation review.

Colorado

Under Contract with The Colorado Department of Health Care Policy and Financing (HCPF), eQHealth Solutions provides services for the ColoradoPAR (prior authorization request) program, effective September 1, 2015. Together, eQHealth and HCPF will serve Medicaid members by focusing on and implementing HCPF's mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Vermont

Since June 2015, eQHealth has been contracted with the State of Vermont, Department of Health Access, as the utilization management and the care coordination software development vendor for a CMS advance planning document grant.

ACCESSIBILITY AND CONTACT INFORMATION

This section provides information about accessing the Comprehensive Medicaid Utilization Management Program (CMUMP) and provides important contact information. At the end of this section we provide a quick reference guide of web site links and toll-free telephone and facsimile (fax) numbers.

Submitting Prior Authorization (Review) Requests

Methods of Submission

All prior authorization (PA) review requests are submitted to eQHealth Solutions (eQHealth) through our proprietary, HIPAA-compliant web-based system, eQSuite™, at ***http://fl.eqhs.com*** .

Submissions are available 24 hours a day, seven days a week.

When You Need Information or Assistance

AHCA and eQHealth are committed to delivering exceptional service to our customers. We offer a variety of ways for you to efficiently obtain the information or assistance you need. In the following sections we identify, by topic or type of assistance needed, useful resources.

For questions or information about the Comprehensive Medicaid Utilization Management Program, the following resources are available:

- eQHealth Solutions customer service staff: Toll free number 855-444-3747.
- Resources available on our Website: ***http://fl.eqhs.com***
  - ***Inpatient Provider Manual***
  - Forms & Downloads
  - eQSuite™ User Guide
  - Education and Training resources:

Questions about Submitting PA Requests or about Using eQSuite

- eQSuite™ User Guide for eQReview for Inpatient Services available on our website: ***http://fl.eqhs.com***
- eQSuite™ Pre Recorded Provider Training

Checking the Status of a PA Request or Submitting an Inquiry about a Request

- Check the status of a previously submitted PA request: Use your secure eQSuite™ login and check the information in your review status report.
- Submit an inquiry using eQSuite's™ helpline module. You may use it when you have a question about a previously submitted PA request.

Both options are available 24 hours a day. Although using eQSuite™ is the most efficient way to obtain information about PA requests, you also may contact our customer service unit.

eQHealth Solutions Customer Service

For general inquiries, inquiries that cannot be addressed through eQSuite™, or if you have a complaint, contact our customer service staff.

The toll-free customer service number is: 855-444-3747 (855-444-eqhs). Staff is available 8:00AM – 5:00PM Eastern Time, Monday through Friday, excluding State-observed holidays.

If you call during non-business hours, you will have the option of leaving a message. Calls received after business hours are answered by our customer staff the following business day.

If you have a complaint and would prefer to submit it in writing, send it to:

eQHealth Solutions, Inc.

Florida Division

Attention: Customer Service Department

5431 Beaumont Center Blvd.

Tampa, FL 33634

Submitting Supporting Documentation

It sometimes will be necessary to submit supporting information for authorization requests. We provide two methods for submitting supporting documentation. You may:

- Upload and directly link the information to the eQSuite™ review record, or
- Download eQHealth's fax cover sheet(s) and fax the information to our toll-free fax number: 855-427-3747.

Requesting a Reconsideration of a Medical Necessity Denial

When eQHealth renders an adverse medical necessity determination for all or some of the requested services, the attending or treating physician, the hospital or the recipient may request reconsideration. Requests for reconsideration may be submitted:

Through eQSuite™, or

- Phone: toll free number 855-977-3747
- Fax: toll free number 855-677-3747
- U.S. mail sent to:

A reconsideration request form is posted on ***http://fl.eqhs.com***, Inpatient tab, Forms and Downloads folder.

eQHealth Solutions, Inc
Florida Division
5431 Beaumont Center .
Tampa, FL 33634

QUICK REFERENCE: CONTACT INFORMATION

- eQHealth Solutions (eQHealth) Submit a prior authorization request:
  - Web site (24x7): http://fl.eqhs.com
  - By fax (only for providers without eQSuite™ access)
  - Submit additional information (24x7):
  - Upload and directly link the information to the eQSuite™ record, or
  - Download the eQHealth cover sheet and fax the information to our toll-free number 855-427-3747

- Submit a reconsideration review request by:
  - Web: ***http://fl.eqhs.com***
  - Phone: 855-977-3747
  - Fax: 855-677-3747
  - U.S. mail sent to:
  - eQHealth Solutions, Inc
    Florida Division
    Attention: Customer Service Department
    5431 Beaumont Center Blvd.
    Tampa, FL 33634

- Obtain information about a previously submitted prior authorization request:
  - eQSuite's™ provider review status reports or helpline module: available 24x7

- Customer service: 855-444-3747
- Speak with a customer service representative 8:00 AM – 5:00 PM Eastern Time, Monday through Friday except State-approved holidays.
- Leave a message 24x7.
- U.S. mail sent to:

  eQHealth Solutions, Inc
  Florida Division

  Attention: Customer Service Department
  5431 Beaumont Center Blvd.
  Tampa, FL 33634

REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

This section provides summary information about the following administrative and review practices and prior authorization requirements.

- Submitting review requests and supporting documentation
- Review request submission timeframes
- Review completion timeframes
- Fair Hearings

Supporting Documentation Requirements and Submission

Submitting Review Requests

Hospitals submit all authorization requests using our proprietary web-based prior authorization system, eQSuite™. Physicians who have access to eQSuite™ also use eQSuite™ to submit prior authorization requests for scheduled elective admissions for surgical procedures.

Required Documentation

It sometimes will be necessary to submit supporting documentation with the authorization requests. For example, a physician may be asked to submit historical clinical information to support the medical necessity of a scheduled elective procedure.

How to Submit Supporting Documentation

The supporting documentation should be submitted electronically using one of two methods:

- Upload and directly link the information to the eQSuite™ review record.
- Download eQHealth's fax cover sheet(s) and submit the information using our 24 x 7 accessible toll-free fax number: 855-409-1521.

For providers who choose to fax the documentation, we provide downloadable special fax cover sheets. Each fax cover sheet includes a bar code that is specific to the particular recipient and for the type of required information. The review-specific fax cover sheets are available for download and printing as soon as the review request is completely entered in eQSuite™ and submitted for review.

DO NOT REUSE OR COPY BAR CODED FAX COVER SHEET(S) – THEY ARE SPECIFIC TO THE REVIEW TYPE FOR A PARTICULAR RECIPIENT AND ARE SPECIFIC TO THE TYPE OF DOCUMENT.

Request Submission Timeframes

Review requests must be submitted within particular timeframes. The timeframe depends on the type of hospitalization and/or on the type of review request. Following are the required review request submission timeframes:

- Elective procedure prior authorization: At least three days before admission.
- Urgent, emergent and trauma admissions (including one day stays): Within 4 hours of the admission (recommended)
- Continued stay review: Prior to the end of the current approval period (applicable only for admissions prior to 7/1/13, BBA and Undocumented Non-Citizen reviews)
- Retrospective prepayment review: Within 12 months of the date of discharge or date of eligibility determination. This includes total length of stay including all documentation at the time of request. **Once requested there will be no modification to days already authorized.**
- Retrospective post-payment review: Upon request of the record or within the timeframe specified by eQHealth
- Expedited reconsideration review
- For a hospitalized patient: Before the patient is discharged
- For scheduled elective surgeries: Within 30 calendar days of the adverse determination
- Standard reconsideration review: Within 30 calendar days of the adverse determination

REVIEW COMPLETION TIMEFRAMES

- The timeframe for completing a review request depends on the type of review. The completion timeframe also may depend on whether the request must be reviewed by a physician reviewer (PR). The completion time is measured from the date we receive all required information.
- Prior authorization review (scheduled elective inpatient procedure and acute admission reviews)
- Nurse reviewer determination: Within 24 hours of receipt of the request
- When referred to a PR: Within one business day of the referral
- Balanced Budget Act (emergency hospitalization) reviews including reviews for undocumented non-citizens
- Nurse reviewer determination: Within one business day of receipt of the request
- When referred to a PR: Within two business days of the referral
- Retrospective review: Within 20 business days, regardless of whether or not a review by a PR is required
- Standard reconsideration: 20 calendar days

Types of Review and Applicability

In this section we summarize the various types of review and note the recipient groups or situations for which they are applicable.

REVIEW TYPES

- Scheduled elective procedure review, performed before admission.

  Required for:

  – Recipients age 21 and older for whom an elective procedure and admission are scheduled

  – Children (under age 21) for whom an elective C-section, inpatient bariatric surgery or hysterectomy is planned

- Admission review

  – Conducted within 24 hours of admission

  – Includes emergency or trauma admissions, urgent admissions and facility-to-facility transfers

- Continued stay review (also referred to as concurrent review)

  – Applicable only to admissions prior to 7/1/13, BBA and undocumented non-citizen reviews: Performed when there has been an admission review approval and hospitalization, beyond the admission review approval end date. The active approval (certification or authorization) end date is the trigger for continued stay review. Review must be requested before the expiration of the current authorization period

  – Hospitalization for emergency services (BBA and undocumented non-citizens) can be authorized only for the duration of the emergency.

  Medicaid will not pay for continuous or episodic services after the emergency has been alleviated.

  Performed:

  – Concurrently (while services are in progress) or retrospectively (after discharge)

  – To verify the reason for the admission and/or continued stay meets the definition of an emergency condition and, if so, the date the emergency situation was alleviated.

- Retrospective prepayment review (or, simply, retrospective review)

  – As approved by the Agency, when the hospital did not adhere to the timeframe for submitting PA requests, failing to obtain admission review while the patient was hospitalized (The frequency of non-compliance with request submission timeframes is monitored by eQHealth Solutions.)

  Performed:

  – Annually for a selected number of inpatient medical records

  – To determine whether the information presented by the provider during admission and continued stay review is verifiable from information in the medical record.

- Reconsideration review

  Expedited:

  – May be requested and will be performed when eQHealth renders an adverse medical necessity determination and:

- The recipient is still hospitalized at the time of the request, or
- For elective surgical procedure PA requests, before the recipient is admitted.

Standard:

- May be requested and will be performed when eQHealth renders an adverse medical necessity determination and the patient has been discharged when the request is received.

First and Second Levels of Review

eQHealth Solutions provides two levels of review. They are distinguished by their:

- Clinical credentials.
- Determinations they may render and how they render those determinations.

With the exception of reconsideration reviews, all inpatient medical and surgical service review requests not approved through our clinical rules-based system algorithms are processed by 1st level reviewers (clinical or nurse reviewers). All reconsideration requests are addressed by physician reviewers.

FIRST LEVEL REVIEW

First Level Reviewer Credentials: Our 1st level reviewers are Florida licensed registered nurses who have at least two years inpatient hospital experience.

First Level Review Determinations:

First level reviewers may render one of the following review determinations:

- Approval: To render this determination the nurse reviewers apply Agency-approved criteria, guidelines and policy. If satisfied the nurse approves the acute inpatient level of care (LOC).
- Pend the request for additional or clarifying information.
- Referral to a second level (physician) peer reviewer. This determination is rendered when:
  - The clinical reviewer's medical necessity criteria are not satisfied; or
  - A prior authorization request is for a surgical procedure that may be experimental or investigational.
- Technical denial: This non-clinical determination is rendered when there is non-compliance or inconsistency with a coverage requirement or with an Agency administrative policy.

Clinical reviewers may not render an adverse determination. When the 1st level reviewer is not able to approve the services on the basis of complete information, they must refer the request to a second level, physician peer reviewer.

First Level Review Clinical Decision Support Tools:

An inpatient medical/surgical authorization request is approved through satisfaction of clinical decision support tools applied by a nurse reviewer.

- When performing review, 1st level reviewers apply Agency-approved clinical criteria, guidelines and policies to substantiate the medical necessity of the LOC. The applicable decision support tools depend on the type of review being performed.
- Agency's proprietary criteria for prior authorization of a particular surgical procedure.
- Emergency admission reviews for BBA: eQHealth's proprietary emergency clinical indicators.
- Emergency admission reviews for Undocumented Non-Citizens: eQHealth's proprietary emergency clinical indicators.

SECOND LEVEL REVIEW

Second Level Reviewer Credentials: Second level (physician peer) reviewers are Florida-licensed physicians of medicine, osteopathy or dentistry who are located in Florida and in active practice.

- Are board certified in the specialty for the service they are asked to review.
- Are on staff at or have active admitting privileges in at least one Florida hospital.
- May not review any case for which a known or potential conflict of interest exists.

Physician Reviewer Role:

Physician peer reviewers review all:

- Authorization requests that cannot be approved by a 1st level reviewer.
- Requests for reconsideration of an adverse determination.

The review is performed by a physician peer reviewer who is of the same or similar specialty as the ordering physician.

Second Level Review Determinations:

For general reviews, a physician reviewer may render one of the following determinations:

- Approval of the acute inpatient LOC as requested.
- Pend the request for additional or clarifying information from the ordering physician.
- Denial: The service is found not to be medically necessary or the emergency event has been alleviated.
- Partial denial: This determination is a finding that a portion of the planned services and/or LOS is not medically necessary, or the emergency event has been alleviated (BBA and undocumented non-citizen reviews only). The result is a reduction in approved services.

When a request for a reconsideration of an adverse determination is submitted, the reviewing physician renders one of the following determinations:

- Uphold the original adverse determination.
- Modify the original determination, approving a portion of the services (BBA and undocumented non-citizen reviews only).
- Reverse the original determination, approving all services.

Inpatient Medical & Surgical Services Authorization Process

In this section we explain the authorization (review) process for acute inpatient medical, surgical and rehabilitative services. The general review process is essentially the same for all types of inpatient services and, with the exception of reconsideration requests, for all types of authorization requests. However, the type authorization request may influence administrative requirements such as the review submission timeframe.

In the following sections we explain the review process for:

- Elective procedure prior authorization requests.
- Admission review requests.
- Continued stay (concurrent) review requests.
- Reconsideration review requests.

The review process for surgical procedure prior authorization and admission review requests is essentially the same. Therefore, these types of review are discussed under a single heading. Since there are some important process differences for reconsideration reviews, that review type is discussed in a separate section.

Procedure Prior Authorization, Admission &, Continued Stay Reviews

Automated Administrative Screening

When the review request is entered in eQSuite™ the system applies a series of edits to ensure review is required and all eligibility, coverage and administrative requirements are satisfied. If there is review exclusion or a failed administrative rule or policy, the review request is cancelled. The system prohibits further review processing and the requesting provider is notified.

- A requesting hospital or a physician using eQSuite™ receives an email advisory message to check the review status report in eQSuite™.

System-based Clinical Criteria First Level Review

eQSuite™ includes system-based medical necessity criteria for certain diagnoses and clinical conditions. The request is routed automatically for review by a nurse.

Nurse Review Process

Administrative Screening of the Request: The nurse (first level or clinical) reviewer first evaluates the request for compliance with administrative requirements that cannot be identified by eQSuite™. If there is a review exclusion or administrative policy breach the nurse issues a technical denial, cancelling the review request. The requesting provider is notified.

Screening for Request Completeness and Pended and Suspended Review Requests: When the request is not cancelled the nurse reviewer screens the submitted clinical information to ensure it is complete, current, legible and compliant. If information is illegible, inadequate or ambiguous the nurse pends the review request.

- Pended review requests: When additional or clarifying clinical information is required, the first level reviewer renders a pend determination. The requesting provider is notified.
- Hospitals and physicians using eQSuite™ are notified electronically as described under "First Level Medical Necessity Review: Approvals."

First Level Medical Necessity Review: After all required information is provided the nurse proceeds with the medical necessity review or, for BBA and undocumented non-citizens reviews, determine the nature of the emergency. The first level reviewer evaluates all clinical information entered in eQSuite™ and any supporting documentation attached to the eQSuite™ record.

Approvals

First level reviewers apply criteria, guidelines and Agency policy to determine whether services are medically necessary or are otherwise allowable. When all applicable criteria and policies are satisfied the nurse approves the services as proposed and approval notifications are generated.

- Electronic notifications are generated to providers who submit requests through eQSuite™. When the determination is rendered, eQSuite™ immediately generates an email notification to the provider who requested the review. The email advises the provider to log in to eQSuite™ and check the secure web-based provider review status report. The provider then may access the report to see the determination.
- Within one business day of the determination we electronically post a written determination notification. Providers may access the notification by using their eQSuite™ secure log on. The notifications can be downloaded and printed.
- The approval information is transmitted to the Medicaid fiscal agent.
- The fiscal agent transmits the prior authorization (PA) number to eQHealth.
- Within 24 hours of our receipt of the PA number, we update the provider's review status report to include the PA number.

If it is an admission prior to 7/1/13, a BBA or an Undocumented Non-Citizen review request, the approval information includes the last date certified. This date serves as the hospital's trigger to submit a continued stay review request if the patient will not be discharged on or before the date following the last day certified.

First level reviewers may not render an adverse determination. They refer to a physician peer reviewer any authorization request they cannot approve. When the first level reviewer refers a review request to a physician reviewer the requesting provider receives notification of the referral.

Second Level (Physician Peer) Review Process

Process Overview

When we schedule physician reviews every effort is made to match the care being reviewed to a physician of the same specialty. The physician peer reviewer (PR) uses his/her clinical experience and judgment and considers all of the following factors:

- As applicable for the patient and for the services under review, whether the services for which authorization is requested are eligible for reimbursement.
- Whether the services for which authorization is requested conform to the Agency's definition of medical necessity.
- As applicable for the patient and for the services under review, consistency with other applicable Agency definitions
- The patient's current clinical condition, diagnosis and prognosis.
- Proposed treatment plan and whether it is adequate and appropriately to meet the patient's unique needs.
- Progress toward meeting treatment plan goals and whether the maximum medical benefit has been achieved.
- Given the patient's clinical status, whether there is an available and appropriate less intensive, less restrictive or more conservative care option.
- Generally accepted professional standards of care.

The PR may approve (authorize) the admission on the basis of the information provided. Or the PR may determine additional information is needed and pend a review request while attempting to obtain the information from the attending or ordering physician.

- **Approval on the basis of available information:** When the available information substantiates the emergency or the medical necessity of the LOC and, when applicable, the proposed LOS, the PR approves the services as requested and the review is completed. Notifications are issued
- **When additional information is required:** If the PR is not able to approve the services on the basis of the available information, they will attempt to speak with the attending or ordering physician to obtain additional or clarifying information. PRs do not render adverse determinations without first attempting to speak with the physician.
- **PR pended review requests:** If the ordering physician is not available when our physician calls, the PR may issue a pend determination at that time. The particular information required is documented in the review record.

The requesting hospital receives an electronic notification of the pended review. Physicians who submitted a surgical procedure prior authorization request by fax receive a mailed notification.

The notification includes the information required and advises the physician that the information must be provided within one business day.

If the requested information is not received within one business day, the PR renders a determination on the basis of the information that is available.

Adverse Determinations

Only a PR may render an adverse determination. As noted in the preceding section, prior to rendering an adverse determination, our PR will attempt to have a peer-to-peer discussion with the attending or ordering physician. If our PR was unable to make any contact with the attending physician a decision will be made based on available information.

There are two types of adverse determinations: denial and partial denial.

- When a denial is rendered, none of the requested services are approved. This type of denial may also be referred to as a full denial.
- When a partial denial is rendered, for an admission prior to 7/1/13, or a BBA or an Undocumented Non-Citizen review request, a portion of the hospitalization is approved but some days are denied. Therefore, there is a reduction in the services for which authorization was requested.

Adverse Determination Notifications:

- Adverse determination notifications are issued to the physician, the hospital that requested the review and to the recipient or legal representative.
- Electronic and written notifications are generated to providers who submit requests through eQSuite™.
- Hardcopy notifications are issued to recipients and to physicians. These notifications are sent within one business day of the determination.
- Written notifications are mailed to recipients.
- For partial denials of an admission prior to 7/1/13, a BBA or an Undocumented Non-Citizen inpatient stay the approval information is transmitted to the fiscal agent. The provider's eQSuite™ status report is updated with the PA number.

  The written notification includes information about the providers' and the recipient's right to a reconsideration of the adverse determination. The recipient's notification also includes information about the right to request a fair hearing.
- For the services that are approved, the approval information is provided to the fiscal agent. The provider's eQSuite™ status report and the final notification are updated with the PA number as previously described for approval determinations.

Reconsideration Reviews

Any party may request a reconsideration of an adverse determination. The only exceptions are:

- When the provider agrees with the adverse determination. In that case reconsideration rights are waived for all parties.
- Undocumented non-citizens do not have reconsideration rights. However, they may request a fair hearing.

Reconsideration requests may be submitted through eQSuite™, by fax, phone or mail. The requesting party must submit additional or clarifying information supporting the medical necessity of the services or the nature of the emergency (BBA & Undocumented Non-Citizens reviews).

Administrative Screening of Reconsideration Requests

When a reconsideration request is received it is screened to ensure compliance with all administrative requirements. If a request does not conform to administrative requirements it is cancelled. Providers receive notification that the request is cancelled.

Reconsideration Review Process

Reconsideration requests bypass first level reviewers. These reviews are performed only by second level reviewers. The PR who performs the review may not have been involved in rendering the original determination. The PR evaluates the information that resulted in the adverse determination and evaluates all additional information submitted.

Types of Determinations and Determination Implication

When the reconsideration determination is a modification or a reversal of the original determination:

- For admissions prior to 7/1/13, BBA and undocumented non-citizen review requests the determination and notification includes the approved LOS (from and through dates shown in the notification).
- The approval information is sent to the fiscal agent and, as necessary, a new PA number is issued as described under “First Level Medical Necessity Review: Approvals”.
- The reconsideration determination is final. When the determination is to modify or uphold the original adverse determination, no further reconsideration is available. However, the recipient may request a fair hearing.

Fraud and Abuse Reporting

eQHealth immediately notifies the Agency of any instance of potential fraud or abuse. The Agency provides direction in what, if any, alteration in the review process is required as a result of the reported incident.