Home Health & Personal Care Services

eQHealth Solutions Provider Manual

2019

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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 Authorization of Home Health and Personal Care Services and provides important contact information. We also provide a quick reference guide of website 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.org***.

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.org***
  - ***Home Health & PCS Provider Manual***
  - Codes that require prior authorization
  - Forms & Downloads
  - eQSuite™ User Guide
  - Education and Training resources:

Questions about Submitting PA Requests or about Using eQSuite

- eQSuite™ User Guide for eQReview for Home Health and PCS Services available on our website: fl.eqhs.org
- 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.

QUICK REFERENCE: CONTACT INFORMATION

- eQHealth Solutions (eQHealth) Submit a prior authorization request:
  - Web site (24x7): http://fl.eqhs.org
  - 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 855-321-3747

- Submit a reconsideration review request by:
  - Web: ***http://fl.eqhs.org***

- 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

Overview: Home Health Services Utilization Management

Services and Codes Subject to prior authorization for recipients receiving skilled and unskilled Home Health visits.

Refer to the Care Coordination Services provider manual for recipients under the age of 21 receiving PDN/PCS Services.

Only certain Healthcare Common Procedure Coding Systems® (HCPCS) codes and modifiers are subject to review by eQHealth. They are identified, by type of service, in the following tables.

Home Health Visit Codes

Code	Modifier	Modifier	Description
T1030			RN Visit
T1030	GY		RN Visit to dually-eligible recipient
T1031			LPN Visits
T1031	GY		LPN visits to dually-eligible recipient
T1021	TD		Home health aide (HHA) visit-associated with skilled nursing services.
T1021	TD	GY	Home health aide (HHA) visit-associated with skilled nursing services to dually-eligible recipient.
T1021			Home health aide (HHA) visit-unassociated with skilled nursing services.
T1021	GY		Home health aide (HHA) visit-unassociated with skilled nursing services to dually-eligible recipient.

Personal Care Service Codes

Code	Modifier	Description
S9122		Personal care rendered by a home health service provider (1 to 24 hours per day)
S9122	TT	Personal care rendered by a home health service provider (1 to 24 hours per day), provided to more than one recipient in the same setting.
S9122	UF	Personal care rendered by a home health service provider (1 to 24 hours per day), provided by more than one provider in the same setting.

Review Requirements and Submitting a PA Request

eQHealth Solutions performs prior authorization for Home Health and Personal Care Services. This section provides summary information about the following authorization requirements:

- Services subject to review

- Submitting PA requests
- Supporting documentation
- Review request submission timeframes
- Review completion timeframes

Supporting Documentation Requirements and Submission

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.

Required Supporting Documentation

Documentation substantiating the need for services must be submitted with the review request.

For information about what supporting documentation is required for what types of providers and services, go to our Web site: http://fl.eqhs.org. The information is located under "Home Health/PCS/PPEC": Forms and Downloads. Documentation requirements may differ for home health agencies and for unlicensed independent or group personal care services provider.

Home Health agencies: See the resource titled, "Home Health Services Required Supporting Documentation".

Unlicensed independent or group personal care providers: See the resource titled, "Unlicensed Independent Personal Care Services Required Supporting Documentation".

These essential resources provide detailed information about what documentation is required, for which home health services it is required and when it is required.

Forms

For some documentation a form is required. For others there may be a choice of forms. The forms that must or may be used are specified in the resources cited in the preceding section, "Required Documentation". For some documentation requirements AHCA has developed special forms that may be used. They may be downloaded from our Web site: http://fl.eqhs.org. Go to "Home Health/PCS/PPEC", Forms and Downloads.

Review Request Submission Timeframes

Types of Review Requests

There are two four of review requests. For each type there is a specified timeframe for submitting the request.

Admission (initial authorization): If it is not possible to obtain all required supporting documentation for recipients pending hospital inpatient discharge, submit the request within five business days of initiating services.

Continued stay (reauthorization) review: Submit the request up to 14 calendar days before the end of the current approval period.

Modification review: Authorization is required if, during an active approval period, a change in the recipient's clinical condition creates a need for an increase or other change in the previously approved services. Submit the request as soon as the need is identified, and the additional services are ordered by the physician, and a revised plan of care (POC) is developed.

Reconsideration review: Performed after an adverse determination if the physician, home health (HH) services provider and/or recipient/legal guardian requests review by another physician. Submit the request within 5 business days of the date of the denial notification.

Review Completion Timeframes

Reviews are completed within particular timeframes. The timeframe depends on the type of HH service and review. The timeframe may also depend on whether the request must be reviewed by a physician. The review completion timeframe is measured from the date we receive all required information.

Home Health visits (skilled nursing and aide visits)

Admission, continued stay and modification:

- When the services can be approved by a nurse: Within one business day.
- When physician review is required: Within two business days.

Reconsideration review:

- Within three business days of the reconsideration request.

Personal Care Services

Admission, continued stay and modification requests:

- When the services can be approved by a nurse: Within one business day
- When physician review is required: Within three business days.
- Additional time may be required if the recipient is in the Care Coordination program.

Reconsideration review:

- Within three business days of the reconsideration request.

FIRST AND SECOND LEVELS OF REVIEW

FIRST LEVEL REVIEW

First Level Reviewer Credentials

Our 1st level reviewers are Florida licensed registered nurses who have at least two years home health experience. Clinical reviewers who review home health care and personal care services (PCS) authorization requests also have at least two years pediatric care experience.

First Level Review Determinations

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

- *Approve* the medical necessity of the services as requested. The determination includes approval of a particular number and frequency of units and the duration of the service.
- *Pend* the request for additional or clarifying information.

- *Refer* the request to a physician reviewer. This determination is rendered when the clinical reviewer's criteria, guidelines and/or length of stay policies are not satisfied. First level reviewers may not render an adverse determination. When the first level reviewer is not able to approve the services on the basis of the complete information provided, (s)he must refer the request to a physician reviewer.

SECOND LEVEL REVIEW

Second Level Reviewer Credentials

Second level physician reviewers are:

- Florida-licensed physicians of medicine or osteopathy or dentistry and are located in Florida and in active practice.
- Board certified in the specialty for the service they are asked to review.
- On staff at or have active admitting privileges in at least one Florida hospital.
- Physician reviewers may not review any request for which a known or potential conflict of interest exists.

Physician Reviewer Role

Our physicians review all:

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

Second Level Review Determinations

For admission, continued stay and, modification reviews a physician reviewer renders one of the following determinations:

- Approval of the services as requested.
- Pend the request for additional or clarifying information from the ordering provider.
- Denial of all services are found not to be medically necessary.
- Partial denial, this determination is a finding that some of the services or the frequency and/or the duration are not medically necessary. The result is a reduction in approved services.

For a reconsideration review the physician renders one of the following determinations:

- *Uphold* the original adverse determination.
- *Modify* the original determination, approving a portion of the services.
- *Reverse* the original determination, approving the services as originally requested.

Home Health Services Prior Authorization Process

In this section we explain the prior authorization (review) process for home health services. The type of service and/or authorization request may influence:

- Administrative requirements.
- Supporting documentation requirements.
- Whether care coordination is implemented.
- The maximum service approval period.

In the following sections we explain the review process for:

- Admission review requests.
- Continued stay requests.
- Modification review requests.
- Retrospective review requests.

Any service-specific process differences are noted. Since there are several processes, differences for reconsideration requests, the reconsideration review process is discussed separately.

Home Health Services Line Items

When providers submit authorization requests for skilled nursing and/or aide services, each home health (HH) service, for which authorization is requested, must be itemized. That is, each service code must be entered in eQSuite as a separate line item. For example, if authorization is requested for both skilled nursing and aide services, a separate line item is required for each. For each service to be provided, the number of service units, the frequency, and the duration must be provided. A determination is rendered for each line item.

Automated Administrative Screening

When the review request is entered in eQSuite™ the system applies a series of edits to ensure authorization by eQHealth is required and that all Medicaid eligibility requirements and policies are satisfied. If there is an eligibility issue or the services are not subject to review, the system will inform and prompt the user to cancel the review.

Nurse Reviewer (1st Level) Screening of the Request

When there are no review exclusions identified by eQSuite™ the system routes the request for first level reviewer screening and review. The clinical reviewer evaluates the entire request for compliance with applicable policies that cannot be applied by the automated process and for compliance with supporting documentation requirements.

Screening for Compliance with Medicaid Policies

When the nurse reviewer identifies an administrative issue/policy breach, the request is cancelled. The requesting provider is notified electronically through eQSuite™. The reason for the cancellation is specified. Since a cancelled review is rendered for an administrative reason, not a clinical or medical necessity reason, it is not subject to reconsideration.

Supporting Documentation Screening

Required supporting documentation must be submitted with the authorization request, must be clear, legible and current and must comply with all AHCA policies. These include the type of documentation required and the documentation content.

If all required supporting documentation is not received with the request, the nurse reviewer pends the request.

Nurse Reviewer Line Item Screening

Administrative Screening

When there are no issues requiring a cancellation of the entire authorization request, the clinical reviewer performs an administrative screening of each individual service line item. The nurse reviewer evaluates each line item to ensure

- Each service is eligible for coverage and no review exclusion exists.
- The supporting documentation requirements applicable to each service are satisfied.
- If a review exclusion exists or an administrative requirement or policy is not satisfied for a particular line item, the first level reviewer issues a technical denial for that service line item. The provider is notified electronically through the system status report that a technical denial has been rendered. The particular service/line item for which the technical denial is rendered is specified. A technical denial, rendered for an administrative reason, is not subject to reconsideration.

Screening Clinical Information and Pending Review Requests

The nurse reviewer screens the submitted clinical information to ensure it is sufficient to complete the medical necessity review. When additional clinical information is required or when the available information requires clarification, the first level reviewer pends the review request and specifies the information or clarification needed.

When the nurse reviewer pends a review request, an advisory email is generated to the requesting provider. The provider accesses the review record to determine what additional information is needed.

Screening for High Risk or High Use Recipients

Our data management system maintains a comprehensive history of all services previously authorized for a recipient. Regardless of the type of home health service, the prior authorization process includes screening historical and current information to identify recipients who may be at risk for high or inappropriate utilization. First level reviewers may request from the provider additional or clarifying information when a recipient is identified as being potentially high risk. They also may consult with a physician reviewer before proceeding with medical necessity review.

Nurse Reviewer Actions following the clinical screening

Except for services for which a technical denial was issued, when all information has been submitted and the clinical information screening is completed, the nurse reviewer proceeds to the next step. The action the nurse takes depends on the type of service for which authorization is requested.

Home Health visits:(skilled nursing or a combination of skilled nursing and HH aide visits): Perform the medical necessity review.

On Admission Reviews Home health aide visits without skilled nursing services: Refer to a PR.

Personal Care Services: Perform the medical necessity review.

First Level Medical Necessity review process

When performing medical necessity review the first level reviewer evaluates all clinical information recorded in eQSuite™ and evaluates the information in the supporting documentation. The reviewer evaluates each service line item individually and renders a separate determination for each.

Approvals

Medical Necessity Approval

First level reviewers apply criteria to determine whether services are medically necessary or are otherwise allowable.

Service Duration Approval

After the medical necessity of services has been substantiated through criteria satisfaction, the nurse reviewer determines the number of units of service, the frequency and the duration that may be approved. The maximum service duration approved by a nurse reviewer is a matter of policy and depends on the type of services. In no event will the number, frequency and duration approved exceed that ordered by the physician, requested by the provider or permitted by policy. The maximum service duration a first level reviewer may approve for medically necessary services is shown below:

- Home Health Visits: 60 calendar days for both admission and continued stay requests.
- Personal Care Services: 180 calendar days for both admissions and continued stay requests.

When all criteria and service duration policies are satisfied the nurse approves the services as proposed by the provider and approval notifications are generated.

Provider notifications:

- Electronic notifications are generated for providers. 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.

- 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.

The approval information includes the last date certified. This date serves as the trigger to submit a continued stay review request if the patient will not be discharged from HH services on or before the date following the last day certified.

Recipient notifications: The recipient (or legal representative) receives a written notification. It is mailed within one business day of the determination.

Referral to a Physician Reviewer

First reviewer any authorization request they cannot approve. This includes requests when criteria are not satisfied and when the requested service duration exceeds that which may be approved by a nurse. It also includes requests for services which, by policy, must be reviewed by a PR.

When the first level reviewer refers a review request to a physician reviewer the requesting provider receives notification of the referral. The notification methods and process are as explained in the preceding section for approvals.

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 PR uses his/her clinical experience and judgment and considers all 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.
- Are applicable for the patient and for the services under review and consistent with other applicable Agency definitions such as the definition of medically complex.

The patient's:

- Current clinical condition, diagnosis and prognosis.
- Treatment plan and whether it is adequate and appropriately customized 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 services 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 medical necessity of the services, the number of service units and the frequency and duration of services, the PR approves the services as requested and the review is completed. Notifications are issued as described under "First Level Medical Necessity Review Process: *Approval Notifications*".

When additional information is required: If the PR is not able to approve the services on the basis of the available information, (s)he attempts 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 provider receives an electronic notification of the pended review. The information must be provided within one business day.

Adverse Determinations

Only a PR may render an adverse determination. As noted in the preceding section, prior to rendering an adverse determination the PR attempts to discuss the request with the treating practitioner. There are two types of adverse determinations: denial and partial denial.

Denial

The physician peer reviewer may render a (full) medical necessity denial of one or more line items.

- The requesting provider receives immediate electronic notification, via email and the eQSuite™ review status report, of the denial.
- A written notification of the denial is posted electronically for the provider. The notice may be downloaded and printed. Written notifications are faxed or mailed to the ordering physician and to the recipient or the recipient's legal representative.
- The written notification includes information about the providers' and recipient's right to a reconsideration of the adverse determination.

Partial Denial

The physician also may render a partial denial for one or more services. When a partial denial is rendered, some of the services are approved and some are denied. Therefore, there is a reduction in the services for which authorization was requested, but there is not a full denial of the services. This adverse determination may involve a denial of the number of units requested, the frequency and/or the duration of the service(s).

For partial denials:

- Notifications are issued to the parties as described in the preceding section, “Denial”.
- The approval information is transmitted to the fiscal agent. The provider’s eQSuite™ status report is updated with the PA number as previously described for approval determinations.

Reconsideration Reviews

Any party may request a reconsideration of an adverse determination.

The written notification of the adverse determination includes information about the right to request reconsideration. It also includes information about how to request reconsideration review. The reconsideration request must be received within 5 business days of the date of the adverse determination.

Home health services providers request reconsideration through eQSuite™. Providers, physicians and recipients may submit reconsideration requests by fax, phone or mail.

The requesting party should submit additional or clarifying information.

Providers, physicians and recipients (or their legal representatives) may submit the additional information by fax or phone.

  – Home Health service providers are strongly encouraged to serve as the coordination entity for the physician and recipient and to submit any additional information on behalf of all.

Administrative Screening of Reconsideration Requests

When a reconsideration request is received it is screened to ensure it complies with policies. It must be received within the required timeframe and must be submitted by a party who is entitled to request a reconsideration. If the request does not conform to these policies:

- The request is denied.
- Notification is sent to the party who requested the reconsideration.

Processing Valid Reconsideration Requests

Only a physician peer reviewer may conduct a reconsideration review. When a valid reconsideration request is received:

- Any additional information submitted by fax or mail is linked to the review record. Information submitted by phone is documented in eQSuite™.

- The review is scheduled for a peer reviewer who was not involved in the original determination.

The PR evaluates all available information including previous information and all additional information submitted. The review is performed according to the process described for all second level reviews.

Types of Determinations and Determination Implications

The reconsideration determination may be one of the following:

- **Modify:** Some of the services are approved and some continue to be denied.
- **Reverse:** The services are approved as originally requested. The original adverse determination is over-turned.
- **Upheld:** The original denial is maintained.

When the reconsideration determination results in a modification or reversal of the original determination:

- The determination and notification will specify the approved number of units, the frequency and the duration. The approved "through date" serves as the provider's trigger to submit a reauthorization request when services are planned beyond that date
- The approval information is transmitted to the fiscal agent. The provider's review status report is updated with the PA number within 24 hours of eQHealth's receipt of the number when a PA was not previously issued.

When the determination is to modify or uphold the original adverse determination, no further reconsideration is available. However, the recipient (or parent or legal guardian) may request a fair hearing.

Completion Timeframe and Notifications

Reconsideration reviews are completed within three business days of eQHealth's receipt of a valid and complete request. Notifications are issued to the parties by the methods and within the timeframes described for all second level review determinations.

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.