Therapy 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 Authorization for Therapy 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.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***
  - ***Therapy 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 Therapy 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: 855-440-3747

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.org***, Multispecialty/ADI tab, Forms and Downloads folder.

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

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 855-440-3747

- 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

REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

eQHealth Solutions performs prior authorization of Therapy 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

Required Documentation

Documentation substantiating the need for Therapy services must be submitted with the review request. When documentation is required or is requested by eQHealth, review will not proceed until it is received.

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.

REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

This section provides summary information about the following therapy services prior authorization (PA or review) requirements:

- Services and codes subject to prior authorization
- Submitting prior authorization requests
- Supporting documentation
- Review request submission timeframes
- Review completion timeframes
- Rules-driven functionality and system edits

Therapy Codes Subject to Prior Authorization

The following table lists the Physician's Current Procedure Terminology (CPT) procedure codes subject to prior authorization. The table is organized by therapy discipline.

CPT Code	Description
97110	Physical Therapy Treatment
97530	Physical Medicine Treatment, Therapeutic Exercise (OT)
92507	Speech Therapy
92508	Group Speech Therapy, per child in the group, per 15 minutes.

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): Prior authorization is required. Submit the request before services are rendered.

Continued stay (reauthorization) review: Prior authorization is required. Submit the request 10 business days, but not more than 15 business days before the end of the current approval period.

Modification review: Authorization is required if a change in the recipient's clinical status necessitates an increase in the previously approved services. Submit the request as soon as the need is identified, and all required supporting documentation is obtained. Submit the request within 12 months of the eligibility determination.

Retrospective: This type of review is applicable only for recipients who are determined to be retroactively eligible for Medicaid and the recipient has been discharged from care (services are completed).

- Submit the review request as soon as eligibility is confirmed and within one year of the retroactive eligibility determination date. The claim should be submitted within 12 months of the eligibility determination date. Please allow sufficient time for completion of the review prior to submission of the claim.
- If services are in progress when the retroactive eligibility is determined, submit an admission review request.

Reconsideration review: This review is performed after an adverse determination if the ordering provider, therapy services provider and/or recipient (or parent or legal guardian) requests review by another eQHealth physician reviewer. Submit the request within 5 business days of the date of the denial notification.

Review Completion Timeframes

eQHealth completes reviews within specific timeframes. The timeframe depends on the type of review. The review completion timeframe is measured from the date eQHealth receives all required information.

- **Admission, Continued Stay and Modification review requests:** Approved at 1st level/nurse review-within 2 business days. When physician review is required, within 3 business days.
- **Retrospective review requests:** Within 20 business days
- **Reconsideration review requests:** Within 3 business days of receipt of the request for reconsideration.

FIRST AND SECOND LEVELS OF REVIEW

PT, OT and SLP

FIRST LEVEL REVIEW

First Level Reviewer Credentials

Our first level (clinical) reviewers are physical therapists, occupational therapists or speech-language pathologists who meet the licensure requirements appropriate licensure requirements. Therapists only review services in their discipline. For example, a licensed physical therapist will review a PT prior authorization request but does not review an OT services request. Nurses who perform therapy reviews have therapy case management 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 the services, the service frequency and the service duration.
- *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 service duration policies are not satisfied. First level reviewers may not render an adverse determination. Only physicians may render a determination that services are not medically necessary. 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.

First Level Review Clinical Decision Support Tools

When performing review, clinical reviewers apply Agency-approved clinical criteria, guidelines and policy to substantiate medical necessity and approve the number of service units, service frequency and duration.

SECOND LEVEL REVIEW

Second Level Reviewer Credentials

Second level physician reviewers are:

- Florida-licensed physicians of medicine or osteopathy 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.

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.

Therapy Services Review Process

In this section we explain the prior authorization (review) process for physical, occupational and speech-language pathology services. The type of review request influences the required supporting documentation and the request submission timeframe. The process for PT, OT and SLP services and for general review requests (initial, continued stay and, modification) is the same and is explained in the first section.

General Review Requests

The process explained in this section is applicable for admission (initial), continues stay, modification and retrospective review requests.

Therapy Service Line Items

When PT, OT and SLP providers submit authorization requests, each therapy service for which authorization is requested must be submitted as a separate authorization request. That is, an OT request for services cannot be submitted with a PT request for services. For each service the number of units, the frequency, and the duration must be provided. A determination is rendered for each request.

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.

Clinical 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

If the clinical reviewer identifies an issue with the request related to Medicaid policy requirements, a technical determination is rendered, and review does not proceed. The requesting provider is notified electronically through eQSuite™. Since a technical determination is rendered for an administrative reason (not a clinical or medical necessity reason) it is not subject to reconsideration.

Screening for Compliance with Supporting Documentation Requirements

Supporting documentation must be submitted with all requests. The documentation must be clear, legible, current, and must comply with all applicable Medicaid policies. If all required supporting documentation is not received with the request, the clinical reviewer “pends” the request.

Clinical Information Screening

The clinical 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.

Pended Review Requests

When the clinical 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.

Medical Necessity Review Process

When all information has been submitted and the clinical information screening is completed, the first level reviewer performs the medical necessity review. When performing the review the clinical reviewer evaluates all clinical information recorded in eQSuite™ and evaluates all submitted supporting documentation information.

Approvals

First level reviewers apply Agency-approved criteria to determine whether services are medically necessary or are otherwise allowable. If the criteria are satisfied, the clinical reviewer renders an approval determination for each service line item.

Therapy Services Duration Approval

After the medical necessity of services has been substantiated through criteria satisfaction, the clinical reviewer approves the number of service units, the frequency and the duration. The

approved units, frequency and duration will not exceed that ordered by the ordering provider, permitted by policy or requested by the provider. For medically necessary therapy services the maximum service duration is 180 calendar days.

Approval Notifications

Approval notifications are generated for Therapy services determined to be medically necessary.

Provider notifications: Electronic notifications are generated for the treating practitioner/provider.

- Electronic notifications are generated for therapy providers. When the determination is rendered, eQSuite™ immediately generates an email notification to the therapy 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 therapy provider then may access the report to see the determination.
- Within one business day of the determination we electronically post a written determination notification. Therapy 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, eQHealth updates the therapy provider's review status report to include the PA number.
- The approval information includes the number of authorized service units, the frequency and the duration. The last date certified serves as the trigger for the therapy provider to submit a continued stay review request if the patient will not be discharged from therapy services at least ten, but not more than 15 days prior to the last day certified.
- Recipient notifications: The recipient or the child's parent or legal guardian receives a written notification. It is mailed within one business day of the determination.

Referral to a Physician Peer Reviewer

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 therapy provider receives notification of the referral. The notification methods and process are as explained in the preceding section for approvals.

Second Level Review Process

The physician peer reviewer (PR) uses clinical experience, knowledge of generally accepted professional standards of care and judgment.

Approval Determinations and Pended Reviews

The physician reviewer determines the medical necessity of each line item, the number of service units, and the frequency and duration of the services.

- *Approval on the basis of available information:* When the available information substantiates the medical necessity of the service(s), units and service duration, the PR approves them as requested and the review is completed. Notifications are issued.
- *When additional information is required:* If a PR is not able to approve the service(s) on the basis of the available information, the PR attempts to speak with the treating provider to obtain additional or clarifying information. If the PR is able to authorize the service(s) on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete, and notifications are issued.
- *PR pended review requests:* If the treating provider is not available when the eQHealth physician reviewer calls, the PR may issue a pend determination at that time. The particular information required is documented in the review record. The provider receives an electronic notification of the pended review.

The information must be provided within the timeframe stated on the pend letter. If the requested information is not received within the timeframe stated on the pend letter, 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 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.
- Within one business day of the determination, a written notification of the denial is posted electronically for the provider. The notice may be downloaded and printed.
- Written notifications are mailed to the ordering provider and to the recipient or the recipient's parent or legal guardian.
- The written notification includes information about the providers' and recipient's right to a reconsideration of the adverse determination.

Partial Denial

The physician peer reviewer also may render a partial denial for the services. When a partial denial is rendered, some of the services are approved and some are denied. Therefore, there is not a complete 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.

For partial denials:

- Notifications are issued to the parties as described in the preceding section, "Denial".

- For the line items 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 a PT, OT or SLP adverse determination. The written notification of the adverse determination includes information about the right to request a reconsideration and how to request one.

- The reconsideration must be requested within 5 business days of the date of the denial notification.
- PT, OT and SLP service providers request reconsideration through eQSuite™. Ordering provider and recipients (or their parents or legal guardians) may submit reconsideration requests by fax, phone or mail.
- The requesting party should submit additional or clarifying information.
- Providers may submit the information using eQSuite™, fax, phone or mail.
- Physicians and recipients (or their parent or guardian) may submit the additional information by fax; mail or phone.

The therapy service provider is strongly encouraged to serve as the coordinating entity for the physician and parent or guardian 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 service units and the duration. The approved “thru date” serves as the provider’s trigger to submit a continued stay request if 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.