REVIEW PROCESS FOR CDC+

Important Numbers

Phone & fax numbers for consultants to contact eQHealth

Voice: 855-444-3747

Fax: 855-440-3747

eQHealth Resources

eQHealth dedicated Florida provider website:

http://fl.eqhs.org

- Click: Home Health/PPEC tab
- Click: Forms and Downloads option

Types of Reviews

Admission (Initial) review

- The first time services are requested for a consumer

Continued service review

- The current authorization is nearing the end of the certification period and the consumer requires continued services.

Modification of an existing authorization

- The consumer's needs change during a certification period because:
  - -Additional services are needed; or
  - -Fewer services are needed.

Reconsideration review

- A request for a second review if an individual involved in the case does not agree with the reviewer's decision to deny some or all of the services requested.

Process

- The consultant faxes required documentation, to eQHealth.
- eQHealth will contact the consultant if the information and/or documentation is incomplete or illegible.
- eQHealth enters the request into eQSuite.

The review process cannot begin until data entry is completed and all required documentation is received.

Levels of Review

- First Level – review by a nurse who may approve the services as submitted, pend the review and send it back to the consultant for additional information, or forward the review to a physician reviewer**.**

First level nurse reviewers may not deny service requests.

- Second Level – review by a board certified physician.

Timelines for Submission & Response

Initial Request	Submission	Review Completion Timeframes
Initial Authorization	Up to **3 days before or 5 business days after** beginning services	1st level review = 1 business day 2ND level review = 2 business days
Reauthorization Up to (continued service)	Up to **10 calendar days** prior to the end of the current approval	
Modification	As soon as the need is identified	
Reconsideration	Within **10 business days** of the adverse determination notification	Within 3 business days

Required Supporting Documentation

Review Posting

Additional Supporting Documentation for CDC+ Consumers

- The current support plan must be submitted with the initial request, and annually thereafter.
- The current cost plan must be submitted with the initial request only (current service plan for PCS and Contract System printout of Client Maintenance Services Plan).

Supporting Documentation for CDC+ Consumers

•All supporting documentation must be provided by the consumer representative to the consultant for submission to eQHealth.

•The consultant will ensure that all required documents are present, complete and include all the required components prior to submission.

• If additional information is needed, the consultant should work with the representative to provide the information.

•The consultant may provide technical assistance, if needed, to complete the submission packet. However, it is not the consultant's responsibility to update or complete the Plan of Care.

•The consultant should never add anything to the Plan of Care before submitting to eQHealth.

Outcome Notification

- eQHealth will mail all outcome letters to the consultant and the consumer.
- If the review results in a denial of all or some of the services requested, the ordering physician will also receive a letter.
- The consultant must notify the APD area office of the authorization outcome.

Reconsideration Reviews

- An adverse determination is a partial or full denial of the services requested.
- A reconsideration of the adverse determination can be requested.
  - Who: The consumer, consumer's family, provider, ordering physician, or representative
  - When: Submission within **10 business days** of the adverse determination.
  - How: consumer, consumer's family, provider, ordering physician, or representative will call or submit a reconsideration form via fax or mail, to eQ Health Solutions including only new or additional information to support the request.
  - What: A second physician review is conducted by a physician *not involved in the initial review.*

Fair Hearing

When requested services are denied in full or part, consumers, or their legal representatives may appeal the decision.

The request **must** be submitted:

- Via a written statement to Medicaid Area Office
- Within **90 calendar days** of the date of the adverse determination notification mailing.
- Within **10 calendar days** of the date of the adverse determination mailing in order to continue services at the current level until eQHealth receives the Fair Hearing determination notice.

eQSuite Access

Consultants can request an eQSuite logon that can be used to:

- Submit authorization requests and submit supporting documentation electronically
- Check status of cases
- Print reports
- View/print outcome letters

Contacts

- Consultants should call or email eQHealth regarding review process questions.

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- Consumer representatives should call the Medicaid area office for questions regarding program and documentation requirements.