ABOUT FLORIDA MEDICAID

THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Florida Agency for Health Care Administration (AHCA or Agency) is the single state agency responsible for administering Florida's Medicaid program which currently serves over 3 million Floridians.

MEDICAID UTILIZATION MANAGEMENT REQUIREMENTS

Both Federal regulations and State statutes require implementation of utilization management strategies for Medicaid health care services. The Code of Federal Regulations 42 C.F.R. 456 directs states to implement utilization controls that safeguard against unnecessary or inappropriate use of Medicaid services, protect against excess payments and assess the quality of health care services.

In addition to 42 CFR 456, various Florida State Statutes direct the Agency to implement a utilization management program for Medicaid services. Section 409.912 (40) Florida Statutes directs the Agency to implement a utilization management program for therapy services (physical, occupational, speech language pathology, and respiratory).

In fulfilling its statutory obligations, AHCA has contracted with a federally designated Quality Improvement Organization (QIO), eQHealth Solutions, to implement the utilization management program for therapy services.

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 utilization and quality management services for a variety of inpatient and non-inpatient settings. Our main office is located in the Tampa area.

Louisiana

Under a federal contract with the Centers for Medicare and Medicaid Services (CMS) since 1986, our office in Louisiana serves as the state's Medicare QIO. As the Louisiana QIO, eQHealth Solutions assists providers achieve significant improvements in areas such as heart attack and pneumonia care, nursing home quality, home care delivery, prevention and wellness and adoption of electronic health records.

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.

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, designing and conducting quality of care studies and quality review services for home and community based waiver services.

For more information about eQHealth Solutions visit www.eqhealthsolutions.com or http://fl.eqhs.org (Florida specific information).

ACCESSIBILITY AND CONTACT INFORMATION

SUBMITTING PRIOR AUTHORIZATION (REVIEW) REQUESTS

Prior authorization (PA or review) requests are submitted to eQHealth Solutions (eQHealth) through our proprietary, HIPAA-compliant Web-based system, eQSuite, at http://fl.eqhs.org. The system is accessible 24 hours a day, seven days a week.

WHEN YOU NEED INFORMATION OR ASSISTANCE

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.

Questions about the Therapy Services Utilization Management Program

For questions or information about the Therapy Services Utilization Management Program, the following resources are available:

- Resources available on our Web site: http://fl.eqhs.org:
  - This Provider Manual as well as manuals for the inpatient, PPEC and home health services programs.
  - Training presentations: Copies of training and education presentations are available under the "Training/Education" tab.
  - Frequently Asked Questions (FAQs): The FAQs are under the "Provider Resources" tab.
- eQHealth's customer service staff: Toll free number 855-444-3747. (See "eQHealth Solutions Customer Service" for hours of operation.)

Questions about Using eQSuite

The *eQSuite User's Guide: Therapy Services* is available on our Web site: http://fl.eqhs.org. User Guides for other services also are available.

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. 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. (See "eQHealth Solutions Customer Service" below.)

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. Staff are available 8:00AM – 5:00PM Monday through Friday, excluding the following State-observed holidays:

- New Year's Day
- Memorial Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Martin Luther King Day
- Independence Day
- Veterans Day
- Christmas Day

If you call during non-business hours, you 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 our toll free customer service fax number: 855-440-3747. Or mail it to:

eQHealth Solutions, Inc.
Florida Division
5802 Benjamin Center Drive, Suite #105
Tampa, FL 33634

Obtain Comprehensive Information about Medicaid Policies

For comprehensive information about Medicaid therapy services coverage, limitations and exclusions, administrative policies and claims submission, there are a number of important resources:

- Florida Provider General Handbook
- Florida Medicaid Therapy Services Coverage and Limitations Handbook
- Florida Medicaid Provider Reimbursement Handbook, CMS-1500
- Florida Medicaid Provider Reimbursement Handbook, UB-04

All Handbooks are available through either of the following Web links:

- http://mymedicaid-Florida.com.
- http://portal.flmmis.com/FLPublic
  - Click on Provider Support, then
  - Click on Provider Handbooks.

SUBMITTING SUPPORTING DOCUMENTATION

Review requests must be accompanied by documentation supporting the need for services. (See Section II – Prior Authorization Requirements: Review Requirements, *Supporting Documentation*.) You may submit requests by:

- Uploading and directly linking the documentation to the review record, or
- Downloading eQHealth's fax cover sheet(s) and faxing the documentation to our toll-free fax number: 855-397-3747

REQUESTING A RECONSIDERATION OF A MEDICAL NECESSITY DENIAL

If eQHealth renders a medical necessity denial for all or some of the requested services, the ordering physician, provider and parent or legal guardian each may request a reconsideration of the decision. Providers submit requests through our Web site: http://fl.eqhs.org. Physicians and recipients (or their parents or legal guardians) may request reconsiderations by:

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

  eQHealth Solutions, Inc.
  Florida Division
  5802 Benjamin Center Dr.
  Suite 105
  Tampa, FL 33634

Important Notice to Providers: Do not send or submit Protected Health Information (PHI) to eQHealth Solutions via email. Please use the Provider Helpline Module within eQSuite for submitting inquiries.

OVERVIEW: THERAPY SERVICES UTILIZATION MANAGEMENT PROGRAM

AUTHORITY

Federal Code 42 C.F.R 456

The Code of Federal Regulations, 42 C.F.R 456 directs States to implement utilization controls that safeguard against unnecessary or inappropriate use of Medicaid services, protect against excess payment and assess quality of services.

Section 409.912 (40), Florida Statutes

Section 409.912 (40), Florida Statutes directs the Agency to implement a utilization management (UM) for Medicaid-eligible recipients for the management of occupational, physical, respiratory and speech-language pathology services. The purpose of the UM program is to ensure therapy services are medically necessary and appropriate.

PROGRAM COMPONENTS

In fulfilling its regulatory and statutory obligations, the Agency has established a comprehensive Medicaid utilization management program (CMUMP) that includes the following services provided by eQHealth Solutions:

- Prior authorization of the following services:
  - Physical therapy (PT)
  - Occupational therapy (OT)
  - Speech-language pathology (SLP)
- Retrospective review of a sample of therapy medical records
- Claims data analyses of respiratory therapy (RT) services

The focus of this manual is the prior authorization component of the UM program. Complete information about Medicaid policies is included in various Florida Medicaid publications. (See Section I – Accessibility and Contact Information: *Obtain Comprehensive Information about Medicaid Policies*.)

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

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.

PHYSICAL THERAPY	
CPT Code	**Code Description**
97110	Physical Therapy Treatment
OCCUPATIONAL THERAPY	
CPT Code	**Code Description**
97530	Physical Medicine Treatment, Therapeutic Exercise (OT)
SPEECH-LANGUAGE PATHOLOGY	
CPT Code	**Code Description**
92507	Speech Therapy
92508	Group Speech Therapy per child in the group per 15 minutes

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Prior authorization (PA or review) requests are submitted electronically using eQHealth's proprietary web-based software, eQSuite.

eQSuite's Key Features

Among eQSuite's many features are:

- Secure HIPAA-compliant technology allowing providers to electronically record and transmit most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users.
- 24x7 access with easy to follow data entry screens.
- Rules-driven functionality and system edits which assist providers by immediately alerting them to such things as situations for which review is not required.

- A reporting module that provides the real time status of all review requests.
- A helpline module through which providers may submit questions about a particular PA request.

Minimal System Requirements

Providers' system requirements for using eQSuite are minimal:

- Computer with Intel Pentium 4 or higher CPU and monitor
- Windows XP SP2 or higher
- 1 GB free hard drive space
- 512 MB memory
- Internet Explorer 7 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher
- Broadband internet connection

eQHealth Solutions will provide information that will explain everything you need to know to access eQSuite.

Each provider designates a Web administrator, and eQHealth will assign a user ID and password for him or her. The administrator, who need not have any information systems technical background, will have access rights to create and maintain user IDs and passwords for each user in your company. Managing system access is a user-friendly, non-technical process.

SUPPORTING DOCUMENTATION

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

Required Documentation

For information about what supporting documentation is required with the different types of review requests, go to our Web site: http://fl.eqhs.org. Click on the Therapy tab and then Forms and Downloads. For comprehensive information about the required content refer to the Florida Medicaid Therapy Services Handbook. It can be downloaded from https://portal.flmmis.com/FLPublic. Click on Provider Support and then on Handbooks.

Forms

AHCA has developed the following forms that may be used for some of the documentation requirements:

- Treatment Form
- Plan of Care Form
- Referral/Evaluation/Prescription Form

We encourage providers to use these forms. They include all of the required content. These forms are available on the AHCA Therapy Services webpage: http://ahca.myflorida.com/medicaid/childhealthservices/therapyserv/index.shtml

You may also download the forms from our Web site: http://fl.eqhs.org. From the Therapy tab go to Forms and Downloads.

How to Submit Supporting Documentation

You may submit supporting documentation by 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 24x7 accessible toll-free fax number: 855-397-3747

For providers who choose to fax the documentation, eQHealth provides 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. For example, there is a specific cover sheet for the plan of care. The review-specific fax cover sheets are available for download and printing as soon as the review request is completely entered in eQSuite.

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 Request Submission Timeframes

There are five types of review requests. For each there is a required timeframe for submitting the request.

- Admission review (initial authorization): Prior authorization is required. Submit the request before services are initiated.
- Continued stay (reauthorization) review: Prior authorization is required. Submit the request up to 14 calendar 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 or change in the previously approved services.
  - Submit the request as soon as the need is identified and all required supporting documentation is obtained.
- Retrospective review
  - This review is performed when Medicaid eligibility is retroactively determined and the recipient is no longer receiving therapy services.

    If eligibility is determined while services are in progress, submit an admission review request as soon as eligibility is confirmed.
  - Submit the request within one year of the eligibility determination.
- 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 10 business days of the date of the denial notification.

REVIEW COMPLETION TIMEFRAMES

Reviews are completed within specific timeframes. The timeframe depends on the type of review and whether the request must be reviewed by an eQHealth physician. The review completion timeframe is measured from the date eQHealth receives all required information.

- Admission, continued stay and modification review requests:
  - When the services can be approved by a first level reviewer: Within 1 business day
  - When physician review is required: Within 3 business days
- Retrospective review requests: Within 20 business days (regardless of whether physician review is necessary)
- Reconsideration review requests: Within 3 business days of the request

FIRST AND SECOND LEVELS OF REVIEW

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 under Chapter 468 or 486, Florida Statutes and who have prior clinical experience. 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 review request. With the Agency's approval, a Florida-licensed registered nurse may review therapy services. 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 service frequency and duration. For therapy services, the reviewers use Milliman Care Guidelines® (Ambulatory Care and Rehabilitation). They also may reference criteria or guidelines published by the applicable professional association, such as the American Physical Therapy Association's Guide to Physical Therapist Practice.

SECOND LEVEL REVIEW

Second Level Reviewer Credentials

Second level physician reviewers meet all requirements in Section 409.9131, Florida Statutes. They 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, modification and retrospective 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: 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 PRIOR AUTHORIZATION 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 all therapy services and for general review requests (initial, continued stay, modification and retrospective) is the same and is explained in the first section. The process for reconsideration requests is somewhat different and is described separately.

GENERAL REVIEW REQUESTS

The process explained in this section is applicable for admission (initial), continued stay (reauthorization), modification and retrospective review requests. Providers are encouraged to review the prior authorization requirements information in Section II of this manual and to be thoroughly familiar with the information in the applicable Florida Medicaid Handbooks.

THERAPY SERVICES LINE ITEMS

When therapy providers submit authorization requests, each therapy 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 each service the number of 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 prior authorization is required and that all Medicaid eligibility and policies are satisfied. If there is an eligibility issue, if the services are not subject to review by eQHealth, or if there is non-compliance with a Medicaid policy, the review request is cancelled.

- The system prohibits further review processing.
- The requesting provider is notified electronically.

CLINICAL REVIEWER SCREENING OF THE REQUEST

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

Screening for Compliance with Medicaid Policies

If the clinical reviewer identifies an issue with the request related to Medicaid policy requirements, the requesting therapy provider is notified electronically through eQSuite. Since a technical denial 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

Required supporting documentation must be submitted with the authorization request, must be clear, legible, and current, and must comply with all Medicaid policies. Refer to Section II – Prior Authorization Requirements: Review Requirements and Submitting PA Requests: *Supporting Documentation*.

If all required supporting documentation is not received with the request, the clinical reviewer pends the request. The therapy provider is notified electronically that the information must be received within one business day. If it is not received within one business day the review request is suspended. The requesting therapy provider is notified electronically. If the information is submitted at a later date eQHealth will re-open the review and review will be performed for services beginning from the date the information is received. (Also see "Clinical Information Screening and Pended and Suspended Review Requests".)

Clinical Information Screening and Pended and Suspended Requests

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 and Suspended 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.
- The requested information must be submitted within one business day.

If eQHealth does not receive the information within one business day of the notification, the review request is *suspended* and no further review processing occurs.

- The provider is notified through the system status report that the request is suspended.
- If the information is submitted at a later date, eQHealth re-opens the request and reviews the services beginning from the date the complete information was received.

First Level Medical Necessity Review

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 the information in the supporting documentation

Approvals

Therapy Services Medical Necessity Approval

First level reviewers apply Agency-approved criteria to determine whether services are medically necessary or are otherwise allowable. (See Section III – Prior Authorization Process: First and Second Levels of Review: *First Level Review Clinical Decision Support Tools*.) 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 all services determined to be medically necessary.

- Therapy provider notifications
  - 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 on or before the date following 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 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 (PHYSICIAN PEER) REVIEW PROCESS

The physician reviewer (PR) uses his/her clinical experience and judgment and considers:

- 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 and Early Periodic, Screening, Diagnosis, and Treatment requirements.
- The recipient's:
  - Current clinical condition, diagnosis and the prognosis.

- Treatment plan and whether it is adequate and appropriately customized to meet the recipient's unique needs.
- Progress toward meeting treatment plan goals and whether the maximum medical benefit has been achieved.

- Generally accepted professional standards of care.

Approval Determinations and Pended Reviews

The physician reviewer determines the medical necessity of each referred service (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 services and of the requested number, frequency and duration of the 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 ordering provider to obtain additional or clarifying information.

  If the PR is able to authorize the services on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete and notifications are issued as described under "First Level Medical Necessity Review Process: *Approval Notifications*".
- *PR pended review requests*: If the ordering provider 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.
  - 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 attempts to discuss the request with the ordering provider.

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

Denial

The physician reviewer may render a (full) medical necessity denial of one or more service 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.
- The recipient's notification also includes information about his/her right to request a fair hearing.

Partial Denial (Service Modification or Reduction in Services)

The physician 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 all parties as described in the preceding section, "Denial".
- For the services that are approved, 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 only exception is when the therapy provider expresses agreement with the adverse determination. In that case the right to reconsideration is waived. 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 10 business days of the date of the denial notification.
- Therapy service providers request reconsideration through eQSuite. Ordering providers 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 one of the methods discussed in Section II – Prior Authorization Requirements: Review Requirements and Submitting PA Requests.
  - 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 physician reviewer who was not involved in the original determination.

Conducting the Review

The physician reviewer 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.
- Uphold: 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 receipt of a valid and complete request by eQHealth. Notifications are issued to all 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.

Term	Acronym or Abbreviation	Definition
Adverse determination or denial		A general term for any unfavorable medical necessity or appropriateness finding resulting from a physician's review of the health care services for which authorization (approval) is requested. An adverse determination may be a (full) denial of the medical necessity of inpatient or non-inpatient services or a partial denial. Partial denials result in a reduction of covered services. ▸ Denial: All planned services and the associated length of stay are found to be not medically necessary or appropriate. ▸ Partial denial: ♦ Inpatient services: A finding that a portion of the hospitalization is not medically necessary or appropriate. ♦ Non-inpatient services: A finding that a portion of the services is not medically necessary or appropriate. The partial denial may be associated with the number of units of service, the frequency of services and/or the duration of services. Providers and recipients may request a reconsideration of an adverse determination. Also see "Non-certification", "Reconsideration" and "Technical denial".
Approval (as it relates to a prior authorization or utilization review determination)		See "Certification determination".
Certification determination or certified services		The prior authorization or utilization review finding that health care services are medically necessary and appropriate. This determination also is referred to as an approval and is rendered by a physician or a 1st level reviewer supported by decision support tools including clinical criteria, guidelines or algorithms.
Continued stay (or recertification) review		A prior authorization or utilization review performed after the initial review and while services are still being provided.
First level determination	1st level determination	A prior authorization or review decision rendered by a 1st level reviewer. (See "First Level Reviewer".) A 1st level determination is one of the following: ▸ Certification of services ▸ Referral to a physician reviewer ▸ Pend: a determination that additional information is needed and requesting the information from the provider

Term	Acronym or Abbreviation	Definition
		▸ Technical denial of the authorization request due to AHCA administrative policy rules
First level reviewer (also referred to as a clinical reviewer)	1st level reviewer	An eQHealth Solutions employee or contractor who maintains an active Florida license as applicable for his clinical profession and who meets all other AHCA-defined credentials required to perform utilization management services and to render medical necessity certifications (approvals). The term includes the licensed professionals who directly or indirectly supervise the staff or contractors and who themselves may perform utilization management services. eQHealth's 1st level reviewers include: ▸ Registered nurses ▸ Physical therapists (therapy services). ▸ Occupational therapists (therapy services). ▸ Speech-language pathologists (therapy services).
Medically necessary or medical necessity		Per Chapter 59G-1.010, Florida Administrative Code: Medically necessary or medical necessity means that the medical or allied care, goods, or services furnished or ordered must: (a) Meet the following conditions: 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain; 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs; 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational; 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provision of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

Term	Acronym or Abbreviation	Definition
		(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, good or services medically necessary or a medically necessity or a covered service.
Milliman Care Guidelines®		eQHealth Solutions maintains a license agreement for its 1st level reviewers to use these proprietary clinical guidelines when performing utilization review or utilization management for certain health care services. The evidence-based guidelines include a broad range of criteria, care pathways, length of stay targets, an array of other medical necessity assessment tools, and a comprehensive bibliography to assist reviewers.
Pend (or pended) review		The status of a review request when additional clinical information is needed to complete the review. eQHealth informs the provider that the review request is pended for additional information. The provider is asked to submit the information within one business day
Prior authorization	PA	A request submitted to the Medicaid quality improvement organization (QIO) for approval to perform one or more procedures or to render other health care services. The request is submitted before the services are provided.
Quality Improvement Organization	QIO	A federally designated organization as set forth in 42 CFR Part 476 to provide quality and cost-management services for the national Medicare Program and for states' Medicaid programs.
Reconsideration		A second review of health care services for which an adverse determination was rendered by a physician and which is performed by a physician who was not involved in the original determination. It may be requested by the treating physician, other provider of the services, and/or the recipient. The outcome of a reconsideration may be one of the following: ▸ Modified - Some of the services are certified (approved) and some continue to be non-certified (denied). ▸ Reversed – Services are certified (approved) as originally submitted. The original determination is over-turned. ▸ Upheld – The original non-certification (denial) is maintained.
Retrospective review		Utilization review performed after health care services have been completed or were otherwise concluded.

Term	Acronym or Abbreviation	Definition
Second level reviewer	2nd level reviewer	A Florida-licensed physician who meets all physician reviewer credentialing requirements established by AHCA and who is employed or contracted by eQHealth Solutions to perform utilization management services. The term includes individual physicians as well as the physicians who directly or indirectly supervise them and who themselves may perform utilization management services. Only a 2nd level reviewer may render an adverse determination.
Supporting documentation		Supporting documentation is particular supplemental documentation required at the time of an authorization request for particular services such as home health and therapy. The nature of the required documentation may vary according to the type of service and the type of authorization request.
Suspended review		The status of a review request when a provider is notified that additional clinical information is needed to complete a review, but the provider does not submit the requested information within the required one business day timeframe. If the requested information is submitted at a later date, the review request is unsuspended.
Technical denial		A determination that the request does not conform to Medicaid requirements. Review is not performed for services for which a technical denial is rendered. Examples of situations that result in a technical denial are: ▸ Patient not an eligible Medicaid recipient. ▸ Recipient ineligible for a particular health care service. ▸ Ineligible provider. ▸ Lack of required supporting documentation. ▸ Duplicate service request. Since a technical denial is not a medical necessity determination, it is not subject to reconsideration.
Unsuspended review		The status of a review request when a provider submits all additional clinical information that was needed to complete a review. When all required information is submitted, eQHealth "unsuspends" the review request and completes the review.
Utilization review	UR	The evaluation of the appropriateness, necessity, and quality of services billed to Medicaid. It also means the evaluation of the use of Medicaid service by recipients.