Behavior Analysis Services

eQHealth Solutions Provider Manual

2019

Table of Contents

Table of Contents 2
About AHCA 3
About eQHealth Solutions 4
Accessibility and Contact Information 5
Review Requirements and Submitting PA Requests 6
Behavior Analysis Services and Review Process 9
Fraud and Abuse Reporting .....

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 Behavior Analysis 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***
  - ***Behavior Health Provider Manual***
  - HCPCS 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 Behavior Analysis Services available on our website: ***http://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

REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

This section provides summary information about the following Behavior Analysis 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

Behavior Analysis HCPCS codes subject to prior authorization or Determination

HCPCS Recipients under 21	Mod 1	Mod 2
H0031 Behavior Assessment	BA	
H0032 Behavior Re Assessment	BA	
H2019 Behavior Analysis- Lead Analyst	BA	
H2012 Behavior Analysis- Asst. Analyst	BA	
H2014 Behavior Analysis- Technician	BA	GK (use this modifier for group therapy - ppl to 6)

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 Behavior Analysis tab and then Education and Training Resources.

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: 855-440-3747

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 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 four 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 at least 5 business days before services are initiated.
- **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.
    - Assessments or Reassessment requests must have a medical necessity determination prior to submitting a continue stay request. If a continue stay request is submitted that request will be cancelled.
- **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.
- **Reconsideration review:** This review is performed after an adverse determination if the ordering provider, BA services provider and/or recipient (or parent or legal guardian) requests review by another eQHealth physician reviewer. Submit the request no later than the date specified on 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 3 business day

  When physician review is required: Within 5 business days.

- 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 licensed practitioners of the healing arts who have been in practice where they regularly provided behavior analysis service within the last two years and who are qualified as a lead analyst in accordance with Section 3.2 of Rule 59G-4.125, FAC.

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 second level reviewers 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 second level 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

Doctoral Level Board Certified Behavior Analyst (BCBA-D) who have been in active practice where they regularly provided behavior analysis service within the last two years.

Our second level reviewers 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: 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 a second level reviewer not associated with the denial 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.

Behavior Analysis Prior Authorization Process

In this section we explain the prior authorization (review) process for Behavior Analysis services. The type of review request influences the required supporting documentation and the request submission timeframe.

General Review Requests

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

Behavior Service Line Items

When providers submit authorization requests, each Behavior Analysis service code the number of units, and duration must be provided.

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 non- compliance with a Medicaid policy, the system prohibits further review processing.

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

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

If all required supporting documentation is not received with the request, the clinical reviewer pends the request. The BA provider is notified electronically that the information must be received for further review processing. If it is not received within two business day the review request is Technically Denied. The requesting provider will need to submit a new case with the required documentation.

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.
- The provider has two business days to respond to the request, if the required information is not received, a Technical Denial will be issued.

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

Behavior Analysis Services Medical Necessity Approval

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.

Behavior Analysis 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 duration. The approved units, and

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

Approval Notifications

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

- Electronic notifications are generated for BA 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.
- Within one business day of the determination we electronically post a written determination notification. BA providers may access the notification by using their secure eQSuite™ 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 BA provider's review status report to include the PA number.
- The approval information includes the number of authorized service units, and the duration. The last date certified serves as the trigger for the provider to submit a continued stay review request if the patient will not be discharged from BA services at least 10, 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 Second Level Reviewer

First level reviewers may not render an adverse determination. They refer to a second level reviewer any authorization requests they cannot approve. When the first level reviewer refers a review request to a second level reviewer the requesting BA 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 Second Level Reviewer (SLR) uses his/her experience, knowledge of generally accepted professional standards of care and judgment.

Approval Determinations and Pended Reviews

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

- Approval on the basis of available information: When the available information substantiates the medical necessity of the service and of the requested units and duration of the service, the SLR approves the service as requested and the review is completed.
- When additional information is required: If the SLR is not able to approve the service on the basis of the available information, (s)he attempts to speak with the ordering provider to obtain additional or clarifying information.
- If the SLR is able to authorize the service on the basis of the additional or clarifying information obtained, an approval determination is rendered.
- SLR pended review requests: If the ordering provider is not available when our physician calls, the SLR 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 two business day.

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

Adverse Determinations

Only a SLR may render an adverse determination. As noted in the preceding section, prior to rendering an adverse determination our SLR attempts to discuss the request with the ordering provider.

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

Denial

The SLR 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.

Partial Denial (Service Modification or Reduction in Services)

The SLR 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.

- Notifications are issued.
- 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 BA 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 30 calendar days of the date of the denial notification.
- BA 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 BA 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 SLR 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 SLR who was not involved in the original determination.

Conducting the Review

The SLR evaluates all available information including previous information and all additional information submitted. The review is then performed.

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 uphold the original adverse determination, no further reconsideration is available.
- If the reconsideration is upheld the Parent/Legal Guardian can request a Fair Hearing. The instructions are outlined in the initial denial letter.

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 determination.

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.