



Provider Utilization Review Manual



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Section A: General Information

1. About eQHealth Solutions, Inc.

eQHealth Solutions, Inc. (eQHealth), under contract to Healthcare and Family Services (HFS) since 2002, serves as Illinois' Quality Improvement Organization (QIO). eQHealth Solutions' role is to evaluate the medical necessity and quality of acute inpatient services for HFS fee-for-service participants. As Illinois' designated QIO, eQHealth provides certification for admissions and continued stay, as well as retrospective prepayment and post-payment review of acute inpatient care in medical/surgical and psychiatric settings. eQHealth also provides quality of services review, determining the medical necessity, reasonableness and appropriateness of care using telephonic and Web-based interactions. Dedicated to continuous quality improvement, eQHealth offers educational services for HFS medical program providers to support these activities.

2. HSI Contact Information

Business address	2050-10 Finley Road Lombard, IL 60148
Business telephone (<i>Monday – Friday, 8 a.m. – 5 p.m.</i>)	(630) 317-5100
Business fax	(630) 317-5101
Toll-free certification line (<i>Monday – Friday, 7 a.m. – 5 p.m.</i>)	(800) 418-4033
Toll-free fax	(800) 418-4039
Provider helpline (<i>Monday – Friday, 8 a.m. – 5 p.m.</i>)	(800) 418-4045
Web site address	il.eqhs.org

3. Provider Services and Resources

a. Provider Helpline

A toll-free provider helpline is available to assist the hospital community at (800) 418-4045. If providers have any questions regarding eQHealth Solutions' program, processes or notifications, helpline staff is available Monday through Friday, from 8 am to 5 pm, CT. Hospitals may also submit helpline inquiries online through the "Reports and Communications" link from our Web site.

b. Provider Education and Training

eQHealth offers free Web-based training sessions. Using a single internet connection and a conference phone at the hospital, any number of staff may attend.

For more information regarding future provider education sessions, visit our Web site at il.eqhs.org.

c. Provider Communications

eQHealth Solutions keeps the provider community informed of program changes and updates through communications sent by mail or fax. These provider communications, or "Provider Updates", can also be viewed online at il.eqhs.org.

d. HealthSystems of Illinois Web site

i. Hospital Communications & Resources

Hospitals can access a variety of useful information at il.eqhs.org including:

- General policy and procedure information in the *Utilization Review Manual*.
- eQHealth Solutions *Provider Updates* and HFS *Informational Notices*.
- Frequently asked questions (FAQs) regarding the utilization review program.



- User guides for *Web-based Review System* and *Provider Web Reports*.
- Provider forms including hospital contact change, reconsideration request form, et al.

ii. Coding Job Aids

The coding job aids contain the ICD-9-CM admitting diagnosis codes from HFS' Attachments A, B and C that are subject to mandatory concurrent review. They are sorted both alphabetically and numerically for your convenience. The coding job aids can be downloaded from il.eqhs.org home page. HFS' Attachments A – D are also found on their Web site at www.hfs.illinois.gov/proqio.

iii. Access to Submit Web Reviews and Run Hospital Specific Reports

Hospitals may register for a free Web account (see section 4.c below for more information).

The Web-based review system is accessed through the "Submit Review Requests" link on the eQHealth Web site and offers providers the flexibility of submitting review requests online 24 hours a day, 365 days a year. Web reviews will be processed by a Utilization Review Coordinator (URC) within one business day from the date of receipt of all necessary information.

This convenient, user-friendly system allows hospitals to perform admission and continued stay review requests, view previous requests, check real-time status of Web review requests, respond to requests for additional information, and easily submit discharge dates online. For detailed instructions on how to use the Web-based review system, download the *eQHealth Solutions Web User Guide from the Provider Resources tab on our Web site*.

eQHealth also offers free training sessions to instruct hospitals how to use the Web-based review system and access provider-specific reports (see Section A.3.b.).

Provider specific reports are accessed through the "Reports and Communications" link on the Web site. Hospitals may use these reports to obtain real-time status of reviews, compare their hospital review data to others throughout the state, and view graphical representations of the data. Hospitals may also access their eQHealth Web account profiles and send online helpline requests from this link. For more information about the individual provider Web reports available, visit the [Provider Resources tab](#) on our Web site.

4. Hospital Contacts

a. HSI Liaisons

The eQHealth Liaison is selected by a member of hospital administration. His/her role is to be the primary contact between eQHealth Solutions and the hospital. All provider communications, notifications, and letters are sent to the liaison. It is important to keep the eQHealth Liaison contact information accurate to ensure all applicable information is received.

b. Quality Liaison

The eQHealth quality contact is selected by a member of hospital administration. His/her role is to be the primary quality contact between eQHealth Solutions and the hospital. All quality communication is sent to this liaison.

c. Web Administrator

To access eQHealth Solutions' Web-based review system and provider-specific reports, each hospital may register for a free Web account and must designate a Web administrator. The Web administrator assigns access rights and log-in IDs for all eQHealth Web users at their facility.



The hospital's eQHealth Liaison, Quality Liaison or Web Administrator may be changed by downloading the *Hospital Contact Form* from the *Quick Resource* section of our homepage..

Section B: Utilization Review

Utilization Review Requirements

eQHealth Solutions is contracted by Healthcare and Family Services (HFS) to perform concurrent admission and continued stay review, and quality of care screening (during and after hospitalization), retrospective prepayment review (after discharge and prior to payment to the hospital), and post-payment review (after discharge and payment to the hospital) to determine the following:

- Whether the services are or were reasonable and medically necessary for the diagnosis and treatment of illness or injury.
- The medical necessity, reasonableness and appropriateness of acute inpatient hospital admissions and discharges.
- Through DRG validation, the validity of the diagnostic and procedural information supplied by the hospital.
- The completeness, adequacy and quality of hospital care provided.
- Whether the quality of the services meet professionally recognized standards of health care.
- Whether those services furnished or proposed to be furnished on an acute inpatient basis could, consistent with the provisions of appropriate medical care, be effectively furnished more economically at a lower level of care.
- The medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of 42 CFR 412.82 and 412.84.

1. Concurrent Review

Through *Informational Notices*, HFS identifies specific admitting diagnosis codes that require concurrent certification review. The list of codes subject to mandatory concurrent review are found on HFS' Attachments A, B, and C and can be found on their Web site at www.hfs.illinois.gov/proqio.

eQHealth Solutions also offers coding job aids that list all codes subject to mandatory concurrent review (see Section A.3.e. for additional information). Concurrent review applies to care reimbursed under a Diagnosis Related Group (DRG) as well as per diem reimbursed hospitalizations. The codes subject to review may be revised periodically and HFS is required to notify hospitals thirty calendar days prior to implementation of any new codes. However, HFS **will not send a notice** to hospitals when the ICD-9-CM coding guidelines mandate a coding change requiring a 4th or 5th digit code extension on codes currently subject to review. All acute medical/surgical and psychiatric care with an admitting diagnosis listed on HFS' Attachments A, B or C must be reviewed through the concurrent review process (for more information regarding HFS' mandatory concurrent review policy, please refer to Section B.2.e).

eQHealth Solutions determines whether certification review is required based on the admitting diagnosis code and the inpatient medical coverage/benefits outlined by HFS' medical program. The admitting diagnosis code submitted to eQHealth is used to determine whether review is necessary for a covered HFS participant. The submitted diagnosis must meet the definition of "admit diagnosis" as defined in the National Uniform Billing Committee Official UB 04 Data Specifications Manual. When review is not required because of coverage issues, eQHealth Solutions cancels the review and a *Notice of Cancelled Request for Review Certification* is sent to the eQHealth Liaison. This notice is not sent for an admitting diagnosis which is not subject to review. When review is required, the initial review is completed by a registered nurse Utilization



Review Coordinator (URC).

For an overview of the Admission/Continued Stay Concurrent Review Process, please refer to the flowchart in Appendix A of this document.

Verification of HFS Participant Contact Information

In July 2006, HFS and McKesson Health Solutions LLC implemented *Your Healthcare Plus*[™], a disease management program that offers specialized care coordination services. To maximize the opportunities presented through this program, it is imperative to have accurate HFS participant contact information to implement timely and effective outreach.

In coordination with the Illinois' disease state management program, effective May 21, 2007, eQHealth requests hospitals to verify the accuracy and provide any updates to HFS participant contact information as part of the utilization review process.

Concurrent Quality of Care Screening

Along with the determination of medical necessity, reasonableness and appropriateness of acute inpatient care, quality screening also takes place during concurrent review. As part of the concurrent review process, nurse reviewers (URCs) will *screen* for potential quality issues based on the clinical information provided by the hospital. If a potential quality concern is identified, the URC will refer the information to a Physician Peer Reviewer (PR). If the information suggests there is, or may be immediate and significant risk to the patient, the PR will contact the treating physician to discuss the situation. In some cases, eQHealth Solutions may request that the hospital submit a medical record for post-payment review after the patient's discharge so that a complete quality review may be performed.

DRG-reimbursed Hospitalizations

Effective with admissions on or after October 1, 2007, HFS no longer requires eQHealth Solutions to perform concurrent *continued stay* review for those inpatient hospital admissions that are *DRG reimbursed*. Hospitals must still obtain certification of the admission, and HFS requires the hospital to contact eQHealth at the time of discharge for a quality of care screening and provide the discharge date. To view HFS' *Informational Notice* dated 09/19/07 regarding this change, click here <http://www.hfs.illinois.gov/hospitals/>.

a. Types of Concurrent Review

i. Admission Review

The review process is initiated when a hospital or physician submits a request for admission certification. The request should be submitted within 24 hours of admission or shortly thereafter, while the patient is still admitted to inpatient care. Hospitalizations with an admitting diagnosis code on HFS' Attachments A, B or C are subject to mandatory concurrent review. The only time a concurrent review may be performed after discharge is for "short stay" hospitalizations of three days or less. Short stays with an admitting diagnosis on HFS' Attachments A, B or C must be reviewed within seven days of the discharge date (for more information about the short stay review policy, see Section B.1.a.iii). ***This admission review process applies to both per diem and DRG reimbursed hospitalizations.***

ii. Continued Stay Review

To facilitate the continued stay review process, eQHealth Solution sends the hospital's designated eQHealth Liaison a report that lists all certifications. The per diem reimbursed hospitalization certifications listed expire within one day. The DRG reimbursed hospitalizations listed require a quality of care screening at the time of discharge and a discharge date. The hospital must verify the *Actual Inpatient Admit Date* and record the



Discharge Date (if applicable) for each patient on the list and fax the list back to HSI. Alternatively, the hospital may use eQHealth's Web-based review system to verify the admission date and conveniently report the discharge dates.

Per Diem Reimbursed Hospitalizations

If the number of medically necessary hospital days exceeds the number certified at the time of the initial or previous review, certification for continued stay must be requested by the hospital one day prior to the last day certified to ensure that all inpatient days will be reviewed prior to billing HFS.

If an admission was certified by eQHealth Solutions but the patient was discharged prior to the hospital's request for continued stay review, the hospital may still request review for the remaining days only if the claim for services has not been submitted. The hospital has up to 12 months from the date of service to request continued stay review from eQHealth and then submit the claim to HFS for payment.

DRG Reimbursed Hospitalizations

DRG reimbursed hospitalizations require a quality of care screening at the time of discharge and reporting of the discharge date. If the admission was certified by eQHealth Solutions, but the patient was discharged prior to the hospital's request for quality of care screening, the hospital may still request this screening if the claim for services has not been submitted. The hospital has up to 12 months from the date of service to request the quality of care screening, provide the discharge date and submit the claim to HFS for payment.

iii. Short Stay Review

For admissions involving short stays of three days or less, hospitals may submit review requests within seven calendar days of discharge. Review requests may be submitted online, 24 hours a day or by calling the toll-free certification line at (800) 418-4033, Monday through Friday, 7 a.m. to 5 p.m., except on designated Federal and State holidays. For a list of HSI holidays, visit our Website under About Us tab.

Web review requests will be processed by the URC within one business day from the date of receipt of all necessary information – excluding weekends and designated Federal and State holidays.

b. Methods of Submission for Concurrent Review

Requests for admission and continued stay review may be submitted:

- 1) Online through HSI's Web-based review system, 24 hours a day, 365 days a year, or
- 2) Through the toll-free certification line, at (800) 418-4033, Monday through Friday, 7 a.m. to 5 p.m., except on designated Federal and State holidays.

Web review requests will be processed by the Utilization Review Coordinator (URC) within one business day from the date of receipt of all necessary information – excluding weekends and designated Federal and State holidays.

c. Review Process

HSI conducts utilization review using Utilization Review Coordinators (URCs) and Physician Peer Reviewers (PRs).

i. Utilization Review Coordinator (URC) Review Process and Outcomes

URCs are registered nurses who receive the hospitals' review requests by phone or by Web. They apply the appropriate medical or behavioral health criteria (most recent InterQual® criteria) to determine medical necessity for admission or continued stay. If the criteria are satisfied such that admission or continued stay request can be certified by the URC, *Thomson Healthcare's Length of Stay Norms* for the North Central Region are referenced as a guide in the assignment of length of stay and the next review point.

Upon review, if the URC cannot make a determination based on the clinical information, they may pend the review for additional information. If criteria are not satisfied or the requested length of stay exceeds what the URC can certify, the request is referred to a Physician Peer Reviewer (PR). The HSI Liaison receives written notification that a PR referral has occurred. Hospitals are encouraged to contact the treating physician to advise them of the referral and that (s)he may be contacted by a PR from eQHealth Solutions to discuss the hospitalization. NOTE: It is important for hospitals to give the treating physician's contact information to eQHealth as part of the review process (if treating physician differs than the attending or there is an alternate phone number). Notifications of certification, additional information or non-certification (denial) are explained in Section 4, herein.

ii. Physician Review Process and Outcomes

The physician review is based on medical judgment and nationally recognized, appropriate clinical care standards. All efforts are made to match the care being reviewed to a physician of the same specialty. Consideration is also given to the geographic region, size and type of hospital in which the services are being delivered. The PR may approve the care and assign the length of stay based on information provided. Only an eQHealth Solutions Physician Peer Reviewer (PR) is able to render an adverse determination. Prior to rendering an adverse determination, the PR will make one attempt to reach the treating physician to discuss the case.

If the PR renders a non-certification or denial determination, notification is sent to the hospital eQHealth Liaison and also to the attending physician. For further information on notices, including reconsiderations, *see Section 4*.

If a non-certification (denial) is the result of the review process, one of the following occurs:

Pre-operative Day(s): If a medical necessity non-certification (denial) is rendered by a PR for one or more pre-operative day(s), payment for that care will not be made by HFS. Verbal and written notice will be issued informing the hospital and attending physician of the denial determination. A reconsideration may be requested according to the process described in Section B3.

Admission Medical Necessity: If non-certification (denial) is rendered by a PR because the hospitalization is determined not to be medically necessary, payment for that care will not be made by HFS. Verbal and written notice will be issued informing the hospital and attending physician of the denial determination. A reconsideration may be requested according to the process described in Section B3.

Concurrent/Continued Stay: If it was determined that continued acute inpatient care is not medically necessary by a PR, payment will not be made by HFS. Verbal and written notice will be issued informing the hospital and attending physician of the denial determination. A reconsideration may be requested for such denials according to the process described in Section B3.

For an overview of the Physician Review process please refer to the Admission/Continued Stay Concurrent Review Process flowchart in Appendix A of this document.

IMPORTANT NOTE: When billing HFS for certified acute inpatient care, the hospital must report the same admitting diagnosis code submitted to eQHealth Solutions during the certification process on the UB-92/UB-04 claim form or 837I electronic claim submittal.

d. Concurrent Review Time Frames

Utilization Review Coordinator (URC) Certifications

URC certification determination is rendered at the time of the telephonic review request or within one business day from the receipt of all necessary information. Web review requests will be processed by the URC within one business day from receipt of all necessary information – excluding weekends and designated Federal and State holidays. Web review requests received after 5 p.m. are considered to be received the next business day. Written notice is issued to the eQHealth Liaison on the day the determination is rendered (see Section 4.a for a list of notifications).

Physician Peer Reviewer (PR) Referrals and Determinations

If a case is referred for physician review, a *Physician Peer Reviewer (PR) Referral Notice* is automatically sent to the hospital eQHealth Liaison. For admission review, PR determinations are rendered within two business days of the review request and receipt of all necessary information. For continued stay review, PR determinations are rendered within one business day.

If there is a medical necessity non-certification (denial), the treating physician is notified verbally at the time of the peer-to-peer discussion. It is important for hospitals to give the treating physician's contact information to eQHealth Solutions as part of the review process (if treating physician differs than the attending or there is an alternate phone number). The review requestor is provided verbal notification within one business day of the adverse determination. Please note that if the requestor's voice mail does not state that it is "confidential", a verbal notification with patient information will not be left. Additionally, written notice of the adverse determination is sent to both the attending physician and the hospital's eQHealth Liaison.

e. Mandatory Concurrent Review

In accordance with their *Informational Notice* dated February 27, 2007, HFS has implemented changes to the utilization review program. Hospitalizations with admissions on or after June 1, 2007, with an admitting diagnosis code on HFS' Attachments A, B or C are subject to mandatory concurrent review or must meet one of HFS' limited exceptions (as defined below). The provider will submit an electronic or paper claim for these hospitalizations. *Mandatory concurrent review only applies to Illinois hospitals and out-of-state hospitals in counties contiguous to Illinois.*

HFS will allow limited exceptions to mandatory concurrent review when:

- An HFS participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the HFS participant was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the HFS participant's Managed Care Organization (MCO) enrollment at the time of admission.
- The HFS participant remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description.

Providers that do not follow the concurrent review process will receive remittance claim rejections with the new error code A88 – "No Certification on File" from HFS. If that claim meets one of the exceptions to mandatory concurrent review the provider may re-submit with a paper claim to their HFS billing consultant, along with a cover memo explaining the exception and any supporting documentation (i.e. exceptions relating to Medicare Part A exhaust require Medicare verification of exhausted benefits). These claims will be manually reviewed by HFS' QIO program management and billing staff and if approved, will suspend for retrospective prepayment review. If the review is cancelled and the claim is re-submitted, the initial cover memo explaining the exception must be submitted with the claim. Those paper claims with exceptions that are not approved will not be payable.

For more information on the mandatory concurrent review exception processes, refer to the HFS billing flowchart included in Appendix A of this document.

f. Children's Mental Health

i. Children's Mental Health Act of 2003/ SASS

In an effort to improve children's mental health, Illinois developed an enhanced Screening, Assessment and Support Services (SASS) system for children, including adolescents, experiencing a mental health crisis.

This initiative is part of the Children's Mental Health Act of 2003 (Public Act 93-0495), which was signed by Governor Blagojevich on August 8, 2003.

This initiative involves a partnership between the Department of Human Services, the Department of Healthcare and Family Services and the Department of Children and Family Services. It creates a single statewide system to serve children experiencing a mental health crisis whose care will require public funding from one of the three agencies. The program emphasizes a family-friendly, single point of entry for all children using this system and will ensure that children receive crisis services in the most appropriate setting.

Additional information regarding the Children's Mental Health Program is available on HFS' Web site at <http://www.hfs.illinois.gov/sass>.

ii. The Role of SASS

The SASS program has two components: A Crisis and Referral Entry System known as CARES that operates through a toll-free phone line with geographically dispersed screening agents known as SASS providers. The handbook for Providers of Screening, Assessment and Support Services (CMH-200) can be downloaded from HFS' Web site at www.hfs.illinois.gov/handbooks/.

For child and adolescent psychiatric hospitalizations, the hospital must notify CARES prior to admission into acute inpatient care. CARES will assign a SASS provider, who must conduct an assessment and be involved in the discharge planning of the patient. *Unless CARES records their involvement in the admission, HSI will not be able to proceed with the review.* The hospital may contact CARES at (800) 345-9049.

2. Retrospective Review

eQHealth Solutions is also contracted by the Illinois Department of Healthcare and Family Services (HFS) to perform retrospective prepayment and post-payment review. Retrospective review is a full scope review which requires a copy of the HFS participant's complete medical record. During retrospective review, the medical necessity of the admission, each day of care (including DRG reimbursed hospitalizations) and the appropriateness of invasive procedures are reviewed. In addition, eQHealth Solutions conducts quality of care review, validates the accuracy of billed ICD-9-CM and DRG codes, and monitors for critical billing errors.

a. Types of Retrospective Review

i. Retrospective Prepayment Review - DRG-Reimbursed Care

All claims submitted to HFS for acute inpatient services with an admitting diagnosis code on HFS' Attachment D will be selected for prepayment review. (Note that admissions with an admitting diagnosis on HFS' Attachments A, B or C may also be selected for prepayment review *for out-of-state hospitals not contiguous to Illinois*, if the admission was not certified through the concurrent review process).

HFS selects cases for hospitalizations subject to retrospective prepayment review and provides eQHealth Solutions with a list of these cases each week. These hospitalizations are selected from claims submitted to HFS. Prepayment review is conducted off-site at eQHealth Solutions. Hospitals are afforded 14 calendar days from the date of *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts to eQHealth Solutions' office for review. Under HFS contract, eQHealth is afforded 44 calendar days to complete the review.

All care subject to review is initially completed by a Utilization Review Coordinator (URC) who applies the appropriate clinical criteria and quality screens to determine medical necessity of the hospitalization and to assess the quality of care. Additionally, coding validation is completed for all principal and secondary diagnosis and procedure codes.

The URC may either certify the admission, confirm that quality screens were not failed, and validate the coding, or (s)he will refer the record to a PR.

The hospital eQHealth Liaison will receive written notice informing him/her that PR referral has occurred. Hospitals are encouraged to contact the treating physician to discuss the referral and to inform the physician that if necessary, the PR may contact him/her to discuss the case. The hospital is afforded seven calendar days to submit any relevant additional information.

Physician review is based on medical judgment, appropriate clinical care standards, and is not limited to review criteria. Efforts are made to match the care being reviewed to a physician of the same specialty. Consideration is also given to the geographic region and size and type of hospital in which the services are being delivered.

For more information on the retrospective review processes, refer to the eQHealth Retrospective Prepayment and Postpayment flowcharts included in Appendix A of this document.

ii. Retrospective Prepayment Review - Per Diem Reimbursed Care

Claims submitted to HFS for acute inpatient services may be selected for retrospective prepayment review and approval prior to HFS rendering payment when the:

1. Admitting diagnosis code is on HFS' Attachments A, B or C, and
2. Admission was not certified through the concurrent review process and meets one of HFS' exceptions to mandatory concurrent review. (See Section B.1.e for further explanation of mandatory concurrent review exceptions).

HFS provides eQHealth Solutions with a list of selected cases for hospitalizations subject to retrospective prepayment review. These hospitalizations are selected on a weekly basis from claims submitted to HFS. Prepayment review is conducted at eQHealth Solutions and hospitals are afforded 14 calendar days from the date on the *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts by mail for review. Under HFS contract, eQHealth is afforded 44 calendar days to complete the review.



All care subject to review is initially completed by a URC who applies the appropriate clinical criteria and quality screens to determine medical necessity of hospitalization and to assess the quality of care. Additionally, coding validation is completed for all principal and secondary diagnoses and procedure codes.

The URC may certify the admission and confirm that quality screens were not failed, or (s)he will refer the record to a Physician Peer Reviewer (PR) for utilization issues or failed quality screens. The hospital eQHealth Liaison will receive written notice that a PR referral has occurred. The eQHealth Liaison is encouraged to contact the treating physician to discuss the referral and to inform the physician that, if necessary, eQHealth's PR may contact him/her to discuss the case. Also, upon receipt of the *Physician Referral Notice* for Retrospective Prepayment Review, the facility or attending physician has seven calendar days to submit any relevant, additional information to eQHealth Solutions that may assist the PR in making their determination.

Physician review is based on medical judgment, appropriate clinical care standards, and is not limited to review criteria. Efforts are made to match the care being reviewed to a physician of the same specialty. Consideration is also given to the geographic region and size and type of hospital in which the services are being delivered.

iii. Retrospective Post-payment Review

Post-payment review is conducted for a random sample of stays following reimbursement to the hospital for the care provided. A sample of hospitalizations is selected by eQHealth Solutions from HFS paid claims data for post-payment review. Post-payment review does not influence payment as does prepayment review. The number of records selected will vary based on the hospital's volume of HFS participant admissions, its case mix and admitting diagnoses.

Post-payment review is conducted offsite at eQHealth Solutions and includes review of the medical necessity of the hospitalization, each day of care (including DRG-reimbursed hospitalizations) and the appropriateness of invasive procedures. In addition, eQHealth conducts quality of care review, validates the clinical information provided during admission and continued stay review and the accuracy of billed ICD-9-CM and DRG codes, and monitors for critical billing errors. For post-payment review, hospitals are afforded 14 calendar days from the date on the *Notice of Selection of Medical Records for Retrospective Review* to submit copied charts to eQHealth's office for review.

b. Method of Submission for Retrospective Review

All retrospective prepayment and post-payment reviews are performed at HSI. Each hospital will be sent a notification of those cases selected for review. The notice will be faxed to the hospital eQHealth's Liaison with a case listing and a tracking sheet for each of the cases selected for review. The hospital must submit the medical record for each of the cases, complete and attach the tracking sheet and securely ship the records to eQHealth Solutions within 14 calendar days from the date of notice. Hospitals will be reimbursed by eQHealth at 10 cents per page or 20 cents for double sided pages for copying reimbursement.

c. Retrospective Review Outcomes

i. Review Determinations Resulting from Retrospective Prepayment Review

Two types of outcomes may occur from retrospective prepayment review. The URC may:

- Certify the hospitalization – medical necessity criteria has been met, quality screens did not fail, no critical billing errors found, and the DRG/coding validated; or



Refer the record to a Physician Peer Reviewer (PR) for one or more of the following: medical necessity criteria was not met, quality screen(s) failed, DRG/coding was not validated.

Adverse Determinations for Retrospective Prepayment Review

Prior to rendering an adverse determination, the PR will make one attempt to discuss the case with the treating physician. The following types of adverse determinations may be rendered for retrospective review:

- **Medical Necessity:** If a non-certification (denial) is rendered by a PR because the admission was determined not to be medically necessary, payment for that care will be denied by HFS. Written notice will be issued informing the hospital and physician of the non-certification determination. A reconsideration may be requested according to the process described in *Section B.3*.
- **Pre-operative Days:** If an adverse determination involves non-certification (denial) by a PR of one or more pre-operative days, payment for that care will be denied by HFS. Denials of any or all pre-operative days will result in the need to re-bill the care to HFS and attach the non-certification of days notice. Written notice will be issued informing the hospital and attending physician of the determination. A *reconsideration* may be requested according to the process described in *Section B.3*.
- **Invasive Procedures:** If it is determined that one or more invasive procedure(s) were not reasonable, medically necessary, or did not meet professionally recognized standards of care, the procedure will not be certified (denied) by the PR. If the case is DRG-reimbursed, the procedure will be removed from the DRG. If the sole reason for admission was for performance of the denied procedure, the hospitalization will not be certified (denied). Non-certification of any invasive procedure will result in the need to re-bill the care to HFS and attach the denial notice. Written notice will be issued informing the hospital and attending physician of the determination. A *reconsideration* may be requested according to the process described in *Section B.3*.
- **Inappropriate Coding:** If an adverse determination involves inaccurate or inappropriate coding, it is necessary to re-bill HFS for the care *only if the revised coding results in a change in the DRG*. This information will be documented on the *Notice of DRG Change*. It is necessary to attach this notice to re-bills. A *reassessment* may be requested for these denials according to the process described in *Section B.3.c*.

eQHealth Solutions will issue periodic reports to HFS listing those cases where the coding validation process results in the recommendation of a change in coding, although payment is not affected.

ii. Review Determinations Resulting from Retrospective Post-payment Review

The URC will confirm the certification of admission and that quality screens were not failed and also look at invasive procedures, validate ICD-9-CM billing and DRG coding as well as screen for critical billing errors. Since this process is post-payment, it does not affect hospital payment; however, any utilization, quality or coding concerns are referred to a PR and reported in summary to HFS.

3. Reconsideration and DRG Reassessment

A hospital or physician who disagrees with a non-certification (denial) determination from eQHealth's Physician Peer Reviewer (PR) has the right to request a reconsideration and to present additional evidence in support of the medical necessity of the stay. In each case where eQHealth Solutions reaches a decision which affects the certification of the hospitalization, they will send the hospital and the attending physician a notice. This notice will also advise them of the



procedures to follow to request a reconsideration or a reassessment. *eQHealth's reconsideration and DRG change reassessment request forms may be downloaded from the eQHealth Web site. **The medical record must be provided with the request for a standard reconsideration.*** The request must substantiate the provider's opinion that:

- The services were medically necessary, reasonable and appropriate based on the patient's signs, symptoms, clinical status and treatment plan, and furnished in the most appropriate setting (for reconsiderations),
- At a minimum, the request must identify the patient, hospital, dates of stay, recipient identification number (RIN), the attending physician's name and telephone number, and should include a copy of the non-certification (denial) notice or include additional evidence to support the accuracy of the billed DRG (for reassessments).

a. Standard Reconsideration

A standard reconsideration may be requested in writing, accompanied by the medical record for an additional review of non-certification (denial) by eQHealth Solutions within 60 calendar days of the denial notification. A *Reconsideration Request Form* may be printed from eQHealth's Web site. An acknowledgement of the receipt of request for consideration will be sent to the eQHealth Liaison and attending physician. This notification explains the procedure for mailing in additional information within 10 calendar days from the date on the notification. eQHealth Solutions is allotted 30 calendar days to render a determination after the receipt of all valid, necessary information for the reconsideration.

b. Expedited Reconsideration

An expedited reconsideration is only available for hospitalizations reviewed through the concurrent review method, and the request must be received by eQHealth Solutions while the patient is still hospitalized. The hospital or physician may send the request for expedited reconsideration along with any additional, pertinent medical information or supporting documentation via mail, facsimile or other acceptable means to HSI. Expedited reconsideration is **not** available when:

- An expedited reconsideration request was received and the patient was discharged from the hospital, or
- There has been a retrospective review denial determination.

For expedited reconsiderations, a determination by a Physician Peer Reviewer (PR) is made within three business days of the receipt of all valid, necessary information.

c. DRG Reassessment

A DRG reassessment may be requested after a PR determines that the billed principal diagnosis, secondary diagnoses, and/or procedural coding is inconsistent with the documentation in the medical record and has resulted in revision of the DRG assignment.

- A *Notice of DRG Change* is sent to the hospital eQHealth Liaison and attending physician and a DRG reassessment may be requested in writing to eQHealth Solutions within 60 calendar days of the notification. When a request for reassessment is received, an *Acknowledgement of the Receipt of Request for Reassessment* will be sent to the eQHealth Liaison and the attending physician. This notification explains the procedure for mailing in additional information within 10 calendar days from the date on the notification. eQHealth Solutions is allotted 30 calendar days to render a determination after the receipt of all valid, necessary information for the reassessment.

Flowcharts with the reconsideration and DRG reassessment process can be found in Appendix A at the back of this document.

4. Provider Notifications

a. Admission/Concurrent Review Notifications

Notice of Review Approval – This notice is issued to the eQHealth Liaison when a request for admission or concurrent/continued stay is certified by the Utilization Review Coordinator (URC) or the Physician Peer Reviewer (PR).

Per Diem Reimbursed Hospitalizations

The *Notice of Review Approval* informs the hospital of the certification, the admit diagnosis code used during the admission certification process, the treatment authorization number (TAN), the number of days certified as well as the next review point.

DRG Reimbursed Hospitalizations

The *Notice of Review Approval* informs the hospital of the certification, the admit diagnosis code used during the admission certification process, the treatment authorization number (TAN), and the notice to contact eQHealth Solutions for a quality of care screening at the time of discharge with the discharge date. Since this is not a length of stay review, the HSI *Notice of Review Approval* for DRG reimbursed hospitalizations does not show days certified (the admission is certified).

Notice of Cancelled Review for Review Certification – This notice is issued to the eQHealth Liaison when a request for certification is received and review will not occur due to non-clinical reasons, e.g., the patient is not eligible for Medicaid, etc. This notice is not issued if the admitting diagnosis code is not subject to review.

Request for Additional Information – Lack of Clinical Information Notice – This notice is issued to the eQHealth Liaison when the URC determines that the request for certification does not provide sufficient clinical information necessary to render a determination. The hospital must supply the requested information within one business day for the review to continue.

Physician Peer Reviewer (PR) Referral Notice – This notice is issued to inform the eQHealth Liaison that a request for certification has been referred to a PR.

Notice of Denial – Certification Request – This denial notice is issued to the eQHealth Liaison when, based on available clinical information, the PR was unable to certify the medical necessity of the admission or continued stay.

Notice of Denial – Pre-operative Day(s) – This denial notice is issued to the eQHealth Liaison when, based on available clinical information, the PR was unable to certify one (1) or more pre-operative day(s) due to lack of medical necessity. However, the hospitalization is certified and the hospital receives a separate *Notice of Review Approval*.

b. Retrospective Review Notifications

Notice of Selection of Medical Records for Offsite Review – This notice accompanies a listing of cases selected for off-site review and is faxed to the eQHealth Liaison. The requested medical records must be copied and submitted to the address designated, and received by the date of notice. An *Offsite Review Inventory Tracking Sheet* is also provided for each record that is to be copied and sent to eQHealth Solutions. **The corresponding tracking sheet must be attached to the copy of the medical record prior to submission to eQHealth Solutions.**

Case Listing for Offsite Review – This is the list of cases that have been selected for off-site review. The list is faxed to the eQHealth Liaison with the *Notice of Selection of Medical Records for Offsite Review* and an *Offsite Review Inventory Tracking Sheet* for each

selected record.

Offsite Review Inventory Tracking Sheet – An *Offsite Review Inventory Tracking Sheet* for each record selected for offsite review is faxed to the hospital's eQHealth Liaison with the *Notice of Selection of Medical Records for Offsite Review* and the *Case Listing for Offsite Review*.

The hospital should record the page count, date, sign and check off the appropriate box if the case is an exception to concurrent review. The corresponding tracking sheet must be attached to the copy of the medical record prior to submission to HSI.

Notice of Cancelled Review – Prepayment Review – This notice is issued to the eQHealth Liaison when a case has been selected for prepayment review but the chart is not available for nurse (URC) or physician review. The claim must be resubmitted to HFS when the chart becomes available for review. Hospitals do not need to attach this notice to the resubmitted claim, but if the claim is for an exception to mandatory concurrent review, a cover memo stating the exception must be included with the claim to HFS. **Note: Copies of medical records should not be sent to HFS or automatically submitted to eQHealth Solutions. Rather, eQHealth will send a Notice of Selection of Medical Records for Offsite Review when HFS notifies them that the case has been re-selected for prepayment review.**

Notice of Incorrect Billing – Prepayment Review – This notice is issued to the eQHealth Liaison when care has been billed incorrectly and cannot be reviewed as billed. Most frequently the incorrect Category of Service (COS) was billed or more than one COS was provided (such as medical and psychiatric care in the same stay) and the incorrect COS was used for the days being billed. This notice is also issued when the incorrect discharge status or incorrect admission and/or discharge dates result in the billing of an incorrect length of stay.

Notice of Cancelled Review Lack of Clinical Information – Prepayment Review – This notice is issued to the eQHealth Liaison when clinical information necessary to render a determination was not provided within the allowed timeframes. The claim must be resubmitted to HFS when the information or chart is available. Hospitals should not attach this notice to the resubmitted claim. Charts should not be sent to HFS. Hospitals should not automatically submit a copy of the information to eQHealth Solutions if this notice is received. eQHealth Solutions will request a copy of the record after it has been notified by HFS that the record has been re-selected for prepayment review.

Physician Peer Reviewer Referral Notice – Prepayment Review – This notice is issued to the eQHealth Liaison when the URC determines that PR referral is required. The purpose of the notice is to allow the hospital time to review and discuss the case with the treating physician, to provide additional supporting documentation to be considered by the PR during review, and to encourage the treating physician to participate in peer-to-peer discussion should it be necessary.

Request for Additional Information – Lack of Clinical Information Notice Prepayment Review – This notice is issued when the URC determines that the medical record does not contain all of the clinical information necessary for application of the nurses' screening criteria. The hospital should supply the requested information within seven calendar days or the prepayment review will be cancelled and a *Notice of Cancelled Review – Lack of Clinical Information – Prepayment Review* will be issued.

Notice of DRG Change – This notice is issued following coding validation and PR determination that the billed principal diagnosis, secondary diagnoses, and/or procedural coding is inconsistent with the documentation in the medical record and has resulted in revision of the DRG assignment. The DRG change will alter the hospital's reimbursement; therefore, the care must be re-billed to HFS with the notice attached.



Notice of Admission Denial– Prepayment Review – This notice is issued when a PR is unable to substantiate the medical necessity of acute inpatient hospitalization. This results in denial of payment by HFS for the entire stay.

Notice of Preoperative Day(s) Denial – Prepayment Review – This notice is issued when a PR is unable to substantiate the medical necessity of the one or more preoperative days. Payment for the denied portion of the stay is denied by HFS.

Notice of Length of Stay Denial – This notice is issued when a PR determines that admission was medically necessary, but he or she is unable to substantiate the medical necessity of the entire length of stay. Payment is denied by HFS for the portion of the stay for which medical necessity is not substantiated for per diem reimbursed hospitalizations.

c. Retrospective Reconsideration Notifications

Notice of Invalid Request for Reconsideration – This notice is issued when a request for reconsideration exceeds the allowed 60 day timeframe for submitting the request.

Notice of Reconsideration Determination – Reversed or

Notice of Reconsideration Determination (Modified or Upheld) – This notice is issued to inform the eQHealth Liaison and attending physician of the reconsideration outcome of a prior denial determination. The original denial may be:

- Upheld - Original denial is upheld, and payment will be denied for that care.
- Modified - Original denial has been modified but not totally reversed. The reconsideration has resulted in medical necessity certification of one or more of the days of care that were originally denied. In order to receive payment for the days that are now certified, this care must be re-billed with the notice attached.
- Reversed - Original denial is completely reversed and the admission or all days of care are certified as medically necessary. In order to receive payment, the care must be re-billed with the notice attached.

Acknowledgement of Receipt of Request for Reconsideration – This notice is issued to the eQHealth Liaison and attending physician to acknowledge receipt of a request for reconsideration. The hospital and the attending physician are afforded 10 calendar days to submit additional information to be considered.

Notice of Invalid Request for Reassessment of a DRG Change – This notice is issued when a request for Reassessment of a prior DRG Change exceeds the allowed 60 day timeframe for submitting the request or does not include required documentation.

Acknowledgement of Receipt of Request for Reassessment – This notice is issued to the eQHealth Liaison and attending physician to acknowledge receipt of a request for reassessment of a prior DRG change. The hospital and the attending physician are afforded 10 days to submit additional information to be considered.

Notice of Reassessment (Re-review) of DRG Change – This notice is issued to inform the hospital eQHealth Liaison and attending physician of the outcome of the reassessment review of a prior DRG change determination. The original DRG change may be:

- Upheld - Original DRG change is upheld.
- Modified - Original DRG change determination has been modified to reflect a revision of the DRG but not a total reversal of the original determination. To receive the correct reimbursement, the care must be re-billed to HFS with the notice attached.
- Reversed - Original DRG change determination is completely reversed. To receive the correct reimbursement, the care must be re-billed to HFS with notice attached.

Section C: Retrospective Quality Review

1. Retrospective Quality Review Process

Under contract with Healthcare and Family Services, eQHealth Solutions performs quality of care review to determine the completeness, adequacy and quality of hospital inpatient care. Objectives of the retrospective quality review process are:

- To perform quality review to determine whether the quality of services provided meet professionally recognized standards of healthcare.
- To work with providers and practitioners to promote patient safety and improve care delivery through peer-to-peer discussions, consultation and quality improvement plans.

Retrospective quality of care review is conducted only when access is available to the complete medical chart through retrospective prepayment or post-payment review. Nurse reviewers apply the Centers for Medicare & Medicaid Services (CMS) quality of care concern categories and, if a potential quality of care concern is identified, it is referred to a Physician Peer Reviewer (PR) for review. A quality of care issue is only confirmed after a full chart review by a PR is completed and the provider has been afforded an opportunity to discuss or submit additional information. Serious quality of care issues are reviewed by a Physician Review Panel consisting of at least three board-certified physicians.

- A Physician Peer Reviewer (PR) reviews the available clinical information, applying his or her clinical knowledge, experience, judgment and professionally recognized standards of care to render a quality determination.

a. Quality Notifications and Timelines

If the issue involves hospital departments only, a letter is mailed to the hospital's eQHealth's Liaison.

If the issue involves any physicians, or both physicians and the hospital, letters are mailed to both the hospital eQHealth Liaison and any cited physicians.

The hospital has 20 calendar days in which to:

- Submit additional information via fax or phone for a PR to review the case, and/or
- Request peer-to-peer discussion

If no additional information is supplied and no request for peer-to-peer discussion is requested by the provider, the quality issue is confirmed and notification is sent to the cited party(ies).

If information is submitted, the case is returned to the original PR for confirmation, downgrading, or resolution of the quality issue based on the information provided and one of the following notifications is sent:

- If all quality issues are resolved or downgraded, a notification of a non-confirmed quality issue is mailed.
- If all quality issues are confirmed, a provider notice of a confirmed quality issue is mailed, indicating that the issue will be forwarded to the Panel.
 - The cited party(ies) will be allowed 15 calendar days to submit additional information and/or request peer to peer discussion with the Panel.

b. Quality Improvement Plan

A Quality Improvement Plan (QIP) is requested when the care was grossly and flagrantly unacceptable and is validated by a panel of physicians. A QIP can also be requested if there is a pattern of care which fails to follow accepted guidelines.

c. Reporting and Monitoring

As required by contract with the Illinois Department of Healthcare and Family Services (HFS), eQHealth Solutions is required to notify HFS of all potential serious quality issues identified by a Physician Peer Reviewer .

In addition, upon approval of the hospital's submitted quality improvement plan by eQHealth Solutions' regional quality review panel, a copy of the approved QIP is sent to HFS and the Bureau of Medicaid Integrity.

The length of time required for quality improvement plan (QIP) monitoring is case-specific, based on the monitoring results. The monitored results need to support that the QIP is achieving and maintaining the target goals. Three to four successive quarters of monitoring is typical. However, monitoring may be extended for a longer period or modifications may be requested if the QIP does not appear to be resolving the quality issue.

eQHealth Solutions reports the Panel's recommendations to HFS.

2. Provider Quality Notifications

Notice of Serious Quality Issue – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) via overnight mail. It informs that, based on the review of the medical record and all information provided, our Physician Peer Reviewer (PR) has determined that a flagrant quality of care issue exists. The notice includes definition of a serious quality issue, a summary of the specific concern and clinical rationale for the determination. It also identifies the source of problem(s) and includes instructions to submit additional information within 20 calendar days if the hospital or attending physician disagrees with the findings.

Notice of Confirmed Serious Quality Issue – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) after initial notice was received and additional information was forwarded to eQHealth Solutions. It also informs that a PR has reviewed the case, along with the additional information provided, including a copy of the medical record and has confirmed the quality issue. The notice also includes a summary of potential concern with the previously assigned severity level, as well as the summary of confirmed concern and severity level assignment. It also states that the case is being forwarded to eQHealth's physician review panel for validation of serious quality issue and gives 15 calendar days to submit additional information deemed appropriate by the physician review panel. The phone number and address for HSI's quality review department are included for contact purposes.

Notice of Non-Confirmed Quality Issue – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) and is sent after an initial *Notice of Potential Severity Level Quality Issue* was issued. It informs that a second Physician Peer Reviewer reviewed the case and all information available, including a copy of the medical record and has made a determination. The notice also includes a summary of the concern, clinical rationale and final determination of the quality issue being resolved or modified.

Notice of a Validated Serious Quality Issue - Panel Review Determination – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) after the *Notice of Confirmed Serious Quality Issue* is issued and eQHealth's physician peer review panel has reviewed and confirmed the quality concern. It includes the summary of confirmed quality concern and previously assigned severity level, as well as a summary of validated quality concern and final determination. A quality improvement plan (QIP) is requested to be submitted within 45 calendar days of this notice. An attachment is included with this notice that includes quality improvement plan guidelines and a sample measurement tool. The QIP will

be evaluated by eQHealth's peer review panel who will accept it as submitted or request modifications to ensure the quality concern is adequately addressed to prevent future occurrences. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Notice of Non-confirmed Quality Issue - Panel Review Determination – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited). This notice is sent after the *Notice of Confirmed Serious Quality Issue* is issued and eQHealth's physician peer review panel has reviewed all information available, including the medical record and made a determination of a non-confirmed quality issue. Notice provides a summary of the concern, clinical rationale and a final determination that the quality issue has been resolved or modified. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Regional Panel Review Determination- Approval of QIP – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited), after receipt of quality improvement plan (QIP) for referenced case(s). It informs party(ies) that eQHealth's quality review panel has reviewed the QIP and determined it is sufficient to address the quality concern(s) identified and to prevent future occurrences and accepts it as submitted. The notice explains that the panel recommends monitoring for four successive quarters to ensure and maintain improvement and provides the first monitoring report due date. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Regional Panel Review Determination - Panel Approval of Revised QIP – This notice is sent to hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) after receipt of the hospital's revised quality improvement plan (QIP) for referenced case(s). It informs party(ies) that eQHealth's quality review panel has reviewed the QIP and determined, that with modifications, it is now sufficient to address the quality concern(s) identified and to prevent future occurrences and accepts it as submitted. The notice explains that the panel recommends monitoring for four successive quarters to ensure and maintain improvement and provides the first monitoring report due date. HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Regional Panel Review Determination - Panel Requests Modification of QIP – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited), after receipt of the hospital's quality improvement plan (QIP) for referenced case(s). It informs that eQHealth's quality review panel reviewed the QIP and determined that essential elements of the QIP were absent or not clearly defined and is not sufficiently comprehensive to address the quality concern(s)/pattern(s) identified to ensure there will be no future occurrences. A request for a revised QIP is stated with a due date of 15 calendar days from the date of the notice. This notice also states that HFS reserves the right to evaluate, modify, approve or disapprove the QIP submitted and/or intensify the review of the quality issue/pattern through measures they deem appropriate.

Regional Panel Review Determination - Panel Approval of QIP Monitoring – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited), after receipt of the hospital's QIP monitoring report. It also informs that eQHealth's quality review panel has determined that the monitoring plan is sufficiently comprehensive to address the quality concern(s)/pattern(s) identified, to ensure there will be no future occurrences. The notice explains that the panel accepts the QIP monitoring report and recommends continued monitoring to ensure and maintain improvement and gives the timeline and due date for the next QIP monitoring report.



Regional Panel Review Determination – Panel Approval of QIP Resolution – This notice is sent to the hospital's eQHealth Quality Liaison and/or the attending physician (whichever is cited) after receipt of the hospital's QIP monitoring report. The notice also informs that eQHealth's quality review panel has determined that the monitoring plan is sufficiently comprehensive to address the quality concern(s)/pattern(s) identified, to ensure there will be no future occurrences. The panel accepts the QIP monitoring report as submitted and has determined that it is no longer necessary to monitor the quality improvement efforts regarding this particular quality concern. The issue is considered resolved.

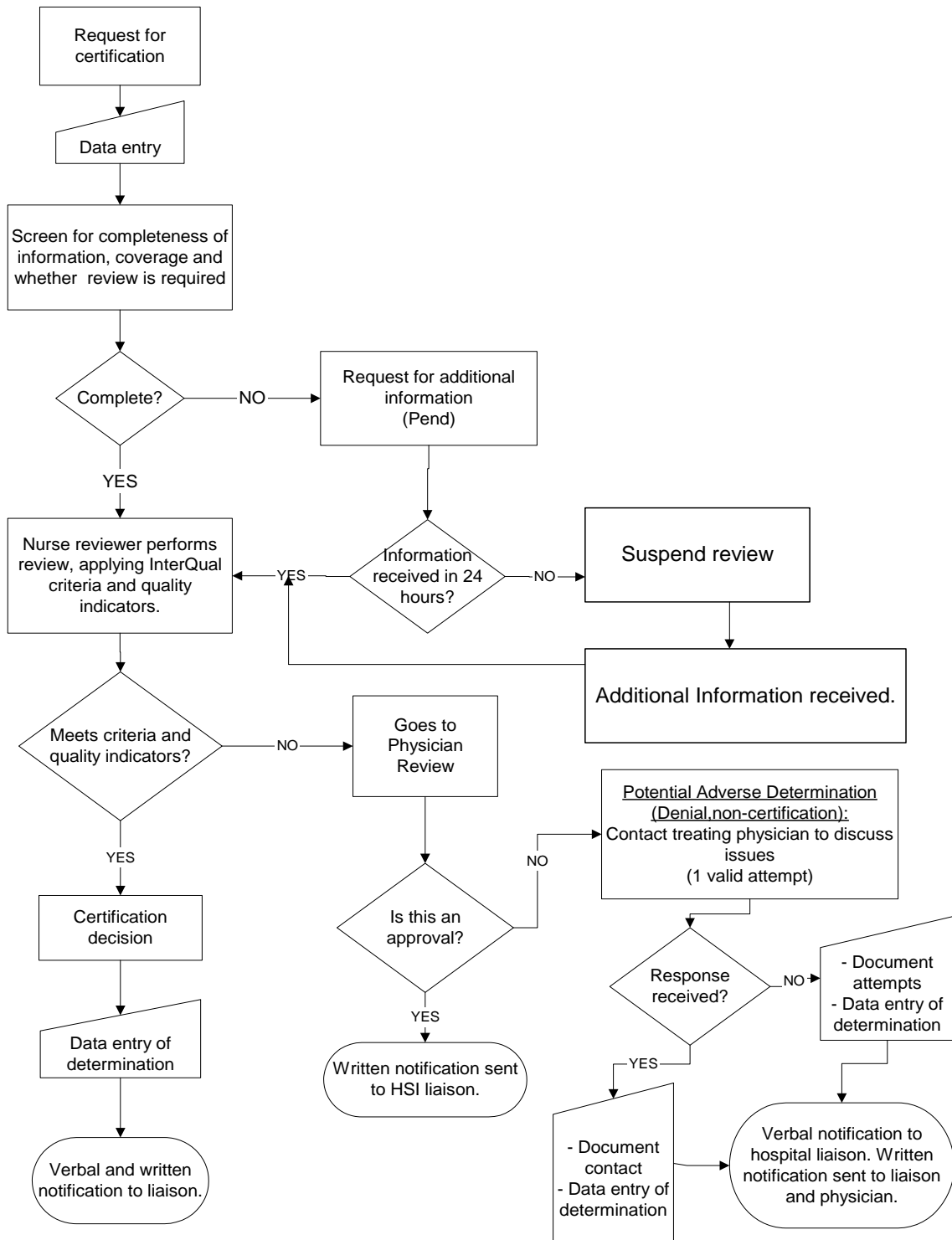
Section D: Appendix A

APPENDIX A

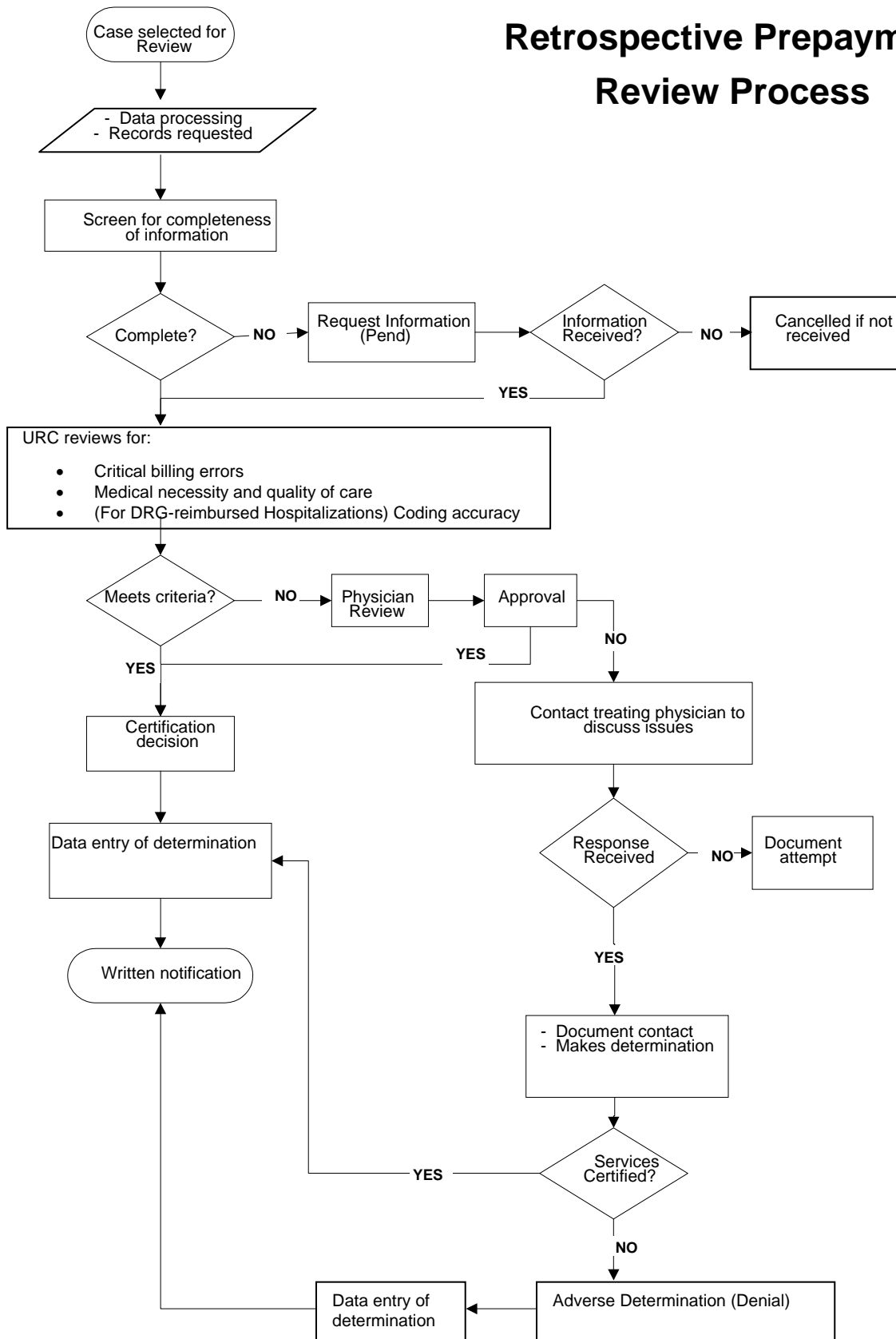
eQHealth Solutions
PROCESS FLOWCHARTS
Admission/Concurrent Review
Retrospective Prepayment Review
Restrospective Post-payment Review
Reconsideration Process
DRG-reassessment Process

HFS BILLING FLOWCHART

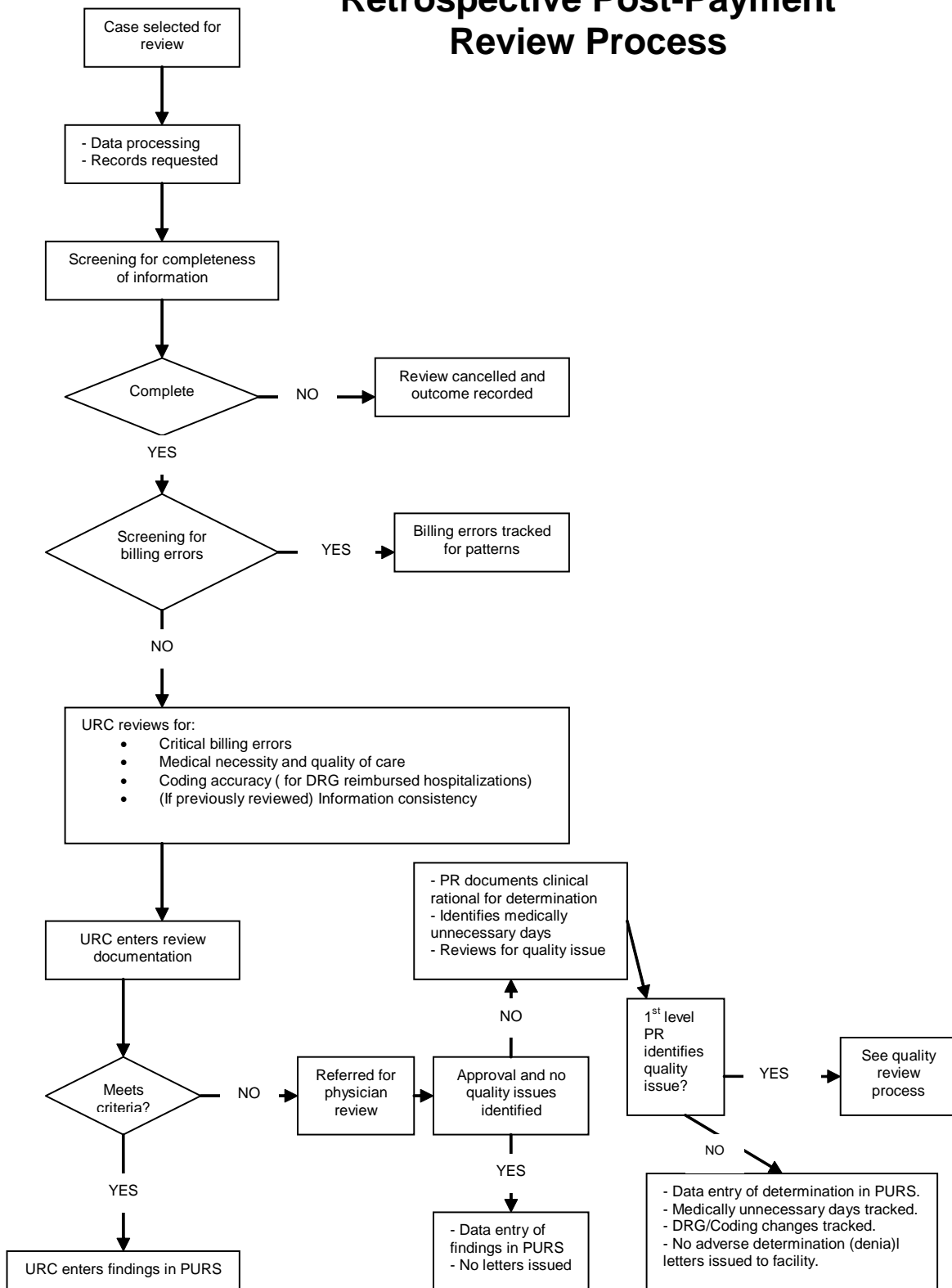
ADMISSION CONCURRENT AND CONTINUED STAY REVIEW PROCESS



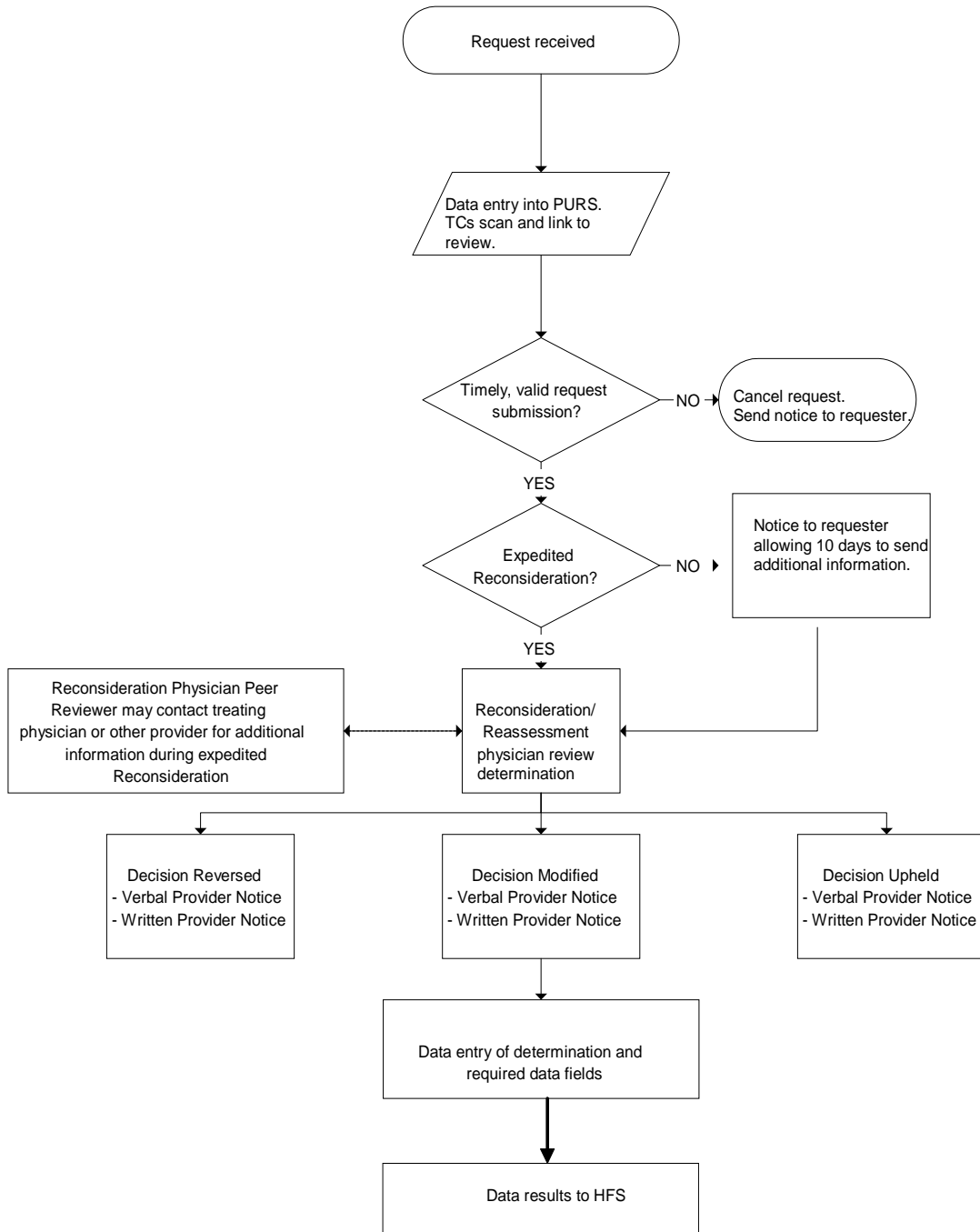
Retrospective Prepayment Review Process



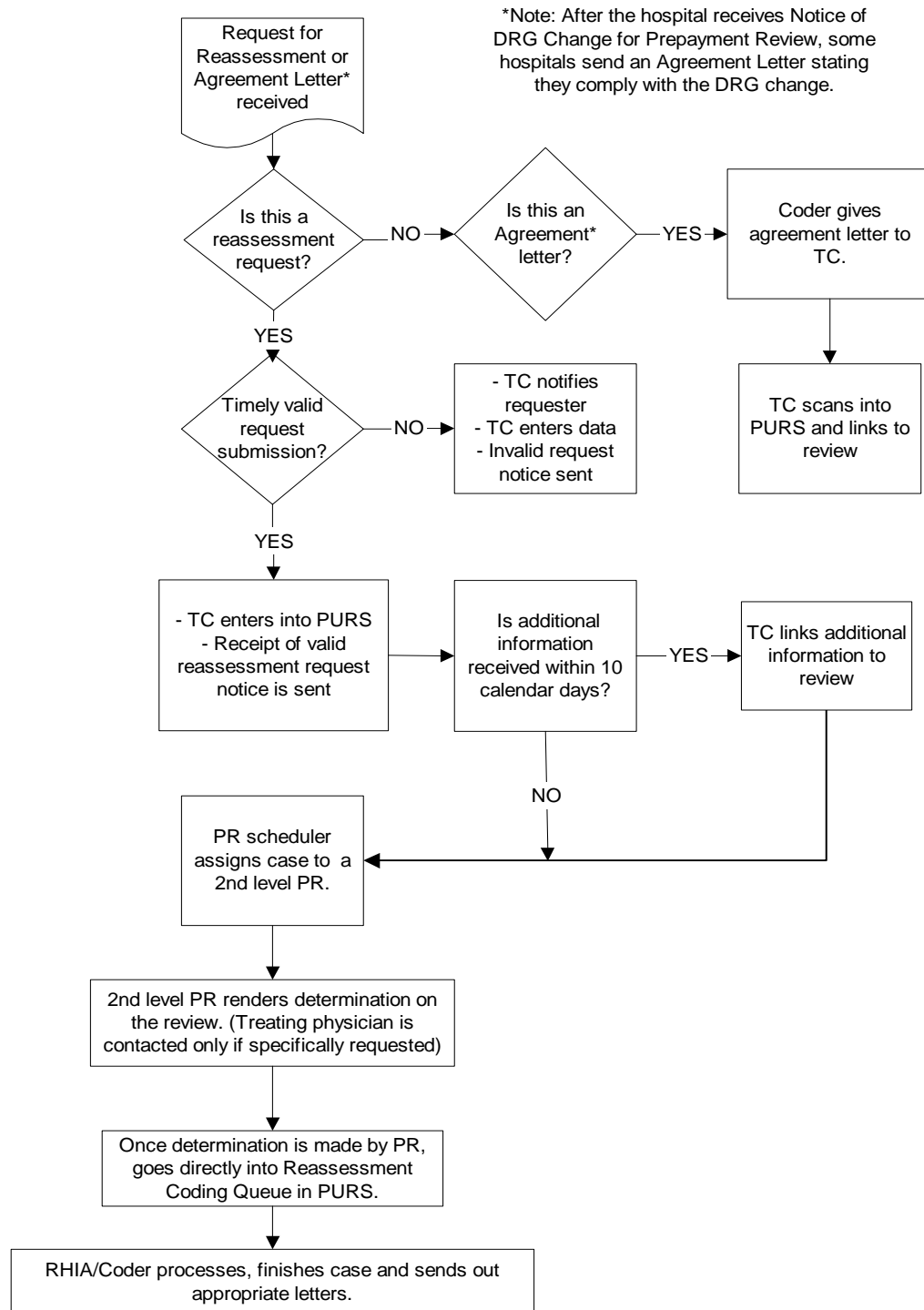
Retrospective Post-Payment Review Process



RECONSIDERATION PROCESS

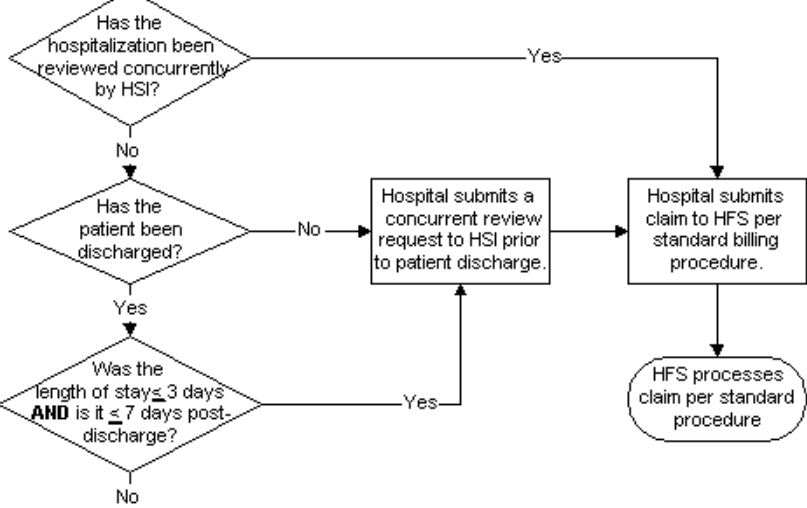


REASSESSMENT PROCESS FOR DRGS - PREPAYMENT



HFS Billing Process: Cases Subject to Mandatory Concurrent Review

Prior to billing, the hospital identifies an inpatient admission involving:
 - An HFS participant WITH
 - An admitting diagnosis on Attachment, A, B or C AND
 - An admission date on or after June 1, 2007



Hospital submits paper or electronic claim to HFS per usual billing practice

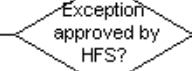
Claim is rejected with HFS error code A88 - No certification on file



Hospital submits a paper claim (WITH cover memo requesting an exception and supporting documentation) to the hospital's assigned HFS billing consultant for manual review by HFS billing and QIO staff.

NOTE:
 Exceptions include:
 - Retroactive HFS eligibility
 - Medicare A coverage exhausted
 - MCO discrepancy
 - Patient unresponsive/unable to identify HFS eligibility
 - Other (hospital provides narrative)

CLAIM IS NOT PAYABLE



HFS suspends the claim for prepayment review

HFS sends selected cases to HSI weekly for their retro prepay list

NOTE: Retrospective review process (HSI) begins at this point only. HSI sends select hospitals a *Notice of Offsite Review* with a case listing requesting retrospective review.