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ABOUT HCPF

THE COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

The Colorado Department of Health Care Policy and Financing (HCPF) oversees and operates Health First Colorado (Colorado's Medicaid Program), Child Health Plan Plus (CHP+), and other public health care programs for Coloradans who qualify.

HCPF'S MISSION

HCPF's mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources. This means that we work to make our members healthier while getting the most for every dollar that is spent.

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.

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.

ACCESSIBILITY

This section provides information about accessing the Inpatient Hospital Review Program and provides important contact information. At the end of this section we provide a quick reference guide of web site links and toll-free telephone and facsimile (fax) numbers.

SUBMITTING PRIOR AUTHORIZATION (REVIEW) REQUESTS

Methods of Submission

All prior authorization review (PAR) requests are submitted to eQHealth Solutions (eQHealth) through our proprietary, HIPAA-compliant web-based system, eQSuite®, at the ColoradoPAR Program website

> The only exception is for physicians who do not have access to eQSuite® and who are submitting PAR requests for scheduled elective inpatient procedures. Physicians without access to eQSuite® may submit review requests by fax to 1-866-940-4288. The applicable forms, available on our ***website***, must be used.

eQSuite® is available for authorization submission twenty-four hours per day, seven days per week for provider convenience, but authorization requests are not required to be entered after hours, on weekends or holidays. eQHealth Solutions and HCPF are available during Monday through Friday, 8:00am-5:00 pm Mountain Standard Time with the exception of State approved holidays. Authorization requests entered outside of those hours, on holidays or weekends will be reviewed the following business day in accordance with already established review timeframes.

WHEN YOU NEED INFORMATION OR ASSISTANCE

HCPF 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, several useful resources.

For questions or information about the ColoradoPAR program including the Outpatient PAR program and the IHRP the following resources are available:

- Resources available on our Website under Provider Resources and the Inpatient tab:
  - This Provider Manual: Inpatient Hospital Review Program Provider Manual which can be found here or under the ***Inpatient*** tab
  - Training presentations: Copies of training and education presentations are available under the "***Provider Education/Training***" tab.

Questions about Submitting PAR Requests or about using eQSuite®

- *eQSuite® User Guide for eQReview for Inpatient Medical Services* available on our ***website.***

Checking the Status of a PAR Request or Submitting an Inquiry about a Request

- Check the status of a previously submitted PAR 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 PAR request.

Both options are available 24 hours a day. Although using eQSuite is the most efficient way to obtain information about PAR 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: 1-888-801-9355. Staff is available 8:00AM – 5:00PM Mountain Standard Time, Monday through Friday, excluding the following State-observed holidays:

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

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.
Colorado Division
Attention: Customer Service Department
5802 Benjamin Center Dr.
Suite #105
Tampa, FL 33634

SUBMITTING SUPPORTING DOCUMENTATION

It will be necessary to submit supporting information for authorization requests. We provide two methods for submitting supporting documentation. You may:

- Upload and directly link the information to the eQSuite® review record, or
- Download eQHealth's fax cover sheet(s) and fax the information to our toll-free fax number: 866-940-4288.

Requesting a Reconsideration of a Medical Necessity Denial

When eQHealth renders an adverse medical necessity determination for all or some of the requested services, the attending or treating physician, the hospital or the recipient may request a reconsideration. eQHealth Solutions offers providers an opportunity to request a reconsideration review when an adverse determination is received. A request for reconsideration is applicable for a) full or partial medical necessity denial determinations, b) Lack of Information (LOI) denials, and c) other technical denials.

A requesting provider, attending or ordering physician may request a PAR reconsideration for a denial due to lack of medical necessity. A request for reconsideration may be submitted electronically via eQSuite®, or by fax or mail within 10 business days from the date of the adverse determination.

Requests for reconsideration may be submitted:

Through eQSuite®, or by:

- Phone: toll free number 888-801-9355
- Fax: toll free number 866-940-4288
- U.S. mail, sent to:

A reconsideration request form is posted on our ***website***:

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

INPATIENT HOSPITAL REVIEW PROGRAM (IHRP) REQUIREMENTS

This section provides summary information about the following administrative and review practices and prior authorization requirements.

- Submitting review requests and supporting documentation
- Review request submission timeframes
- Review completion timeframes

SUBMITTING REVIEW REQUESTS AND SUPPORTING DOCUMENTATION

Submitting Review Requests

All prior authorization review (PAR) requests are submitted through eQHealth's proprietary online portal, eQSuite®.

Submitting Supporting Documentation

It will be necessary to submit supporting documentation with the authorization requests to support the medical necessity of the inpatient admission.

REQUEST SUBMISSION TIMEFRAMES

Review requests must be submitted within the designated timeframes. The timeframe depends on the type of hospitalization and/or on the type of review request. Following are the required review request submission timeframes:

- Scheduled and pre-planned admissions prior authorization: Prior to admission
- Unscheduled direct or non-urgent admission: Within one (1) business day of admission
- Urgent/emergency admissions: Within one (1) business day of admission to an inpatient facility or immediately upon stabilization of an emergent condition as defined by the ***Emergency Medical Treatment & Labor Act***.
- Concurrent Review (Continued stay): On day 4 of the hospital admission if the member has not been discharged (Day 1 is considered the day that the member is admitted to an inpatient setting, and a concurrent review would be entered on the 4th day if the member remains admitted as an inpatient.)
- Reconsideration review request for denied services

- For a hospitalized patient: Before the patient is discharged

- For scheduled and pre-planned admissions: Within 10 calendar days of the adverse determination
  - Expedited Reconsideration: Within two business days
  - Standard reconsideration: Within four business days

Type of Request	Guidelines for Providers
Scheduled, non-emergent admissions	Submitted review prior to admission
Unscheduled, nonemergent Admission	Within 1 business day of admission
Unscheduled, emergent Admission	Within 1 business Day of stabilization of Patient per ***EMTALA***
Concurrent Review	On day 4 of the hospital admission if the member has not been discharged (Day 1 is considered the day that the member is admitted to an inpatient setting, and a concurrent review would be entered on the 4th day if the member remains admitted as an inpatient.)
Pended Question Response time	1.5 Business Days (example: If a review was pended to provider on Thursday afternoon, the Provider would have until Monday Morning, prior to 12pm, to respond before it is denied for Lack of Information.)
Request a Peer-to-Peer	Providers may request within 5 Business days of the Medical Necessity Denial
Request a Reconsideration	Providers may request within 4 Business days of the Denial

Retrospective Review

In some cases, a member may not be eligible for Colorado Medicaid at the time of admission, but retroactive eligibility is obtained while hospitalized or post discharge. A retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

Concurrent Review

Concurrent reviews, also known as continued stay reviews, are required when an admission review has been approved and the member remains in the hospital at day four following the admission.

These requests will be submitted at day four of the member's hospitalization and should include any documentation not submitted upon admission related to the member's care. Day 1 is considered the day that the member is admitted to an inpatient setting, and a concurrent review would be entered on the 4th day if the member remains admitted as an inpatient.

Complex Case Review

The purpose of complex case review is to ensure the provision of care and the level of care is appropriate for the member's needs and current status.

Complex Case Review will be performed on hospital day four for members admitted with diagnoses in the following categories:

- Neonates
- Sepsis
- Respiratory Failure
- Pneumonia

As stated previously, Inpatient Facilities will be required to submit a concurrent review at day four. The requests with diagnoses included in the categories listed above will be reviewed by the nurse and/or physician reviewer for complex case review. All documentation related to the member's current stay should be submitted and will be reviewed for the following indicators:

- Appropriate length of stay
- Appropriate level of care
- Appropriate initiation of discharge planning if applicable
- Other quality indicators as deemed appropriate by HCPF
- eQHealth may request additional information as part of the review for those inpatient admissions that fall under the Complex Case designation.

REVIEW COMPLETION TIMEFRAMES

The timeframe for completing a review request depends on the type of review. The completion time is measured from the date we receive all necessary and/or requested information to make a determination.

- Prior authorization review (scheduled elective inpatient procedure and acute admission reviews): Within one business day
- Nurse reviewer determination: Within one business day
- When referred to a PR: Within one business day
- Continued Stay Review: Within one business day
- Complex Case Review: Within four business days
- Expedited Reconsideration: Within two business days
- Standard reconsideration: Within four business days

If an authorization request is submitted without supporting documents, one business day will be allowed to upload or fax the required clinical documentation. If not received within one business day, the request will be pended back to the provider to request the documents. If supporting documents are not received within 1.5 business days from the pend request, the authorization will be technically denied for lack of information.

SUBMITTING PRIOR AUTHORIZATION REQUESTS AND SUPPORTING DOCUMENTATION

SUBMITTING PRIOR AUTHORIZATION REQUESTS

Hospitals submit all authorization requests using our proprietary web-based prior authorization system, eQSuite®.

eQSuite® Key System Features

Among eQSuite®'s many features are:

- Secure HIPAA-compliant technology allowing providers to electronically record and transmit most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users.
- 24/7 access.
- A reporting module that provides the real time status of all review requests.
- A helpline module through which providers may submit questions about a request.

Minimal Computer System Requirements

- Any of the two most recent versions of Internet Explorer, Google Chrome, Mozilla Firefox, Safari using a Broadband internet connection.
- ***Minimum System Requirements***

SYSTEM ADMINISTRATOR

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

SUBMITTING SUPPORTING DOCUMENTATION

Sometimes it will be necessary to provide supporting documentation with authorization requests. We offer two methods of submitting the documentation: You may:

- Upload and directly link the information to the eQSuite® review record, or
- Download eQSuite®'s Principal Barcoded coversheet. You then complete the information and fax it toll-free to 1-866-940-4288.

If you choose to fax the information you must eQSuite®'s Principal Barcoded coversheet. Each cover sheet includes a bar code that is specific to the particular request and for the type of required information. The bar code enables automatically linking of the information to the correct recipient review record. Use of the bar-coded cover sheet:

- Assures the image is linked to the correct review record.
- Provides an effective audit trail for ensuring that all required documentation submitted is complete and timely.

FIRST AND SECOND LEVELS OF REVIEW

eQHealth Solutions, with the exception of reconsideration reviews, reviews all inpatient admissions potentially two levels of review. In the first level review, the request is reviewed and processed by 1st level reviewers (clinical or nurse reviewers). If necessary, a second level review is completed by a Physician Reviewer. All reconsideration requests are addressed by physician reviewers.

FIRST LEVEL REVIEW

First Level Review Determinations

Our 1st level reviewers are licensed nurses. First level reviewers may render one of the following review determinations:

- Approval: To render this determination the nurse reviewers apply Agency-approved criteria, guidelines and policy. If satisfied the nurse approves the acute inpatient level of care (LOC).
- Pend the request for additional, supporting or clarifying information.
- Refer to a second level (physician) reviewer. This determination is rendered when:
  - The medical necessity criteria has not been met; or
  - A prior authorization request is for a procedure that may be experimental or investigational.
- Technical denial: This non-clinical determination is rendered when there is non-compliance or inconsistency with a coverage requirement or with an Agency administrative policy.

While the Nurse reviewers may deny for a technical reason, they are not able to render an adverse medical appropriateness determination. When the 1st level reviewer is not able to approve the services based on the provided clinical information, they must refer the request to a second level, physician reviewer.

SECOND LEVEL REVIEW

Physician Reviewer Role

Second level (physician) reviewers are licensed physicians of medicine or osteopathy. Physician reviewers review all:

- Authorization requests that cannot be approved by a 1st level Nurse Reviewer.
- Requests for reconsideration of an adverse determination.

Second Level Review Determinations

For general reviews, a physician reviewer may render one of the following determinations:

- Approval as requested.
- Pend the request for additional or clarifying information from the ordering physician.
- Denial: The service is found not to be medically appropriate.

ADVERSE DETERMINATIONS

An adverse determination, or denial, can occur for one of two reasons: the information submitted does not substantiate medical necessity, or technical policy requirements have not been met.

A **technical denial** occurs when the authorization submitted does not meet the policy requirements set forth by the Department of Health Care, Policy & Financing. Some examples of technical denials include:

- Untimely authorization submission
- Requested information was not received
- The authorization request is a duplicate to another approved or denied request
- The requested service is already approved with another provider

A **medical necessity, or medical appropriateness,** denial occurs when an eQHealth physician determines that the information submitted does not substantiate the medical necessity of the service requested. These medical necessity denials will be reviewed by eQHealth and the Department's

RECONSIDERATIONS

A reconsideration request may be submitted within 4 calendar days of an adverse determination and any additional information may be submitted for review during the reconsideration process. Examples of additional information include but are not limited to:

- Updated physician's orders
- Additional laboratory tests, diagnostic imaging studies, or specialty physician consultations that were not available or were not provided during the original review
- Any other pertinent medical information to support the request

When a request for a reconsideration of a medical necessity denial is submitted, the physician reviewing for the reconsideration will be different than the initial physician reviewer and have the same clinical expertise as the attending physician.

Upon completion of the reconsideration, one of the following determinations will be rendered:

- Uphold the original adverse determination.
- Reverse the original determination, approving all services.

For additional information regarding reconsiderations, including how to request one, please see the ***Reconsideration Provider Guide***.

PEER TO PEER CONSULTATIONS

Peer to peer (P2P) consultations offer the ordering physician the opportunity to discuss a medical necessity denial determination with an eQHealth physician reviewer following the initial adverse determination. This can occur during an ongoing reconsideration or following an upheld reconsideration, or without a reconsideration. These consultations offer the member's physician the opportunity to understand why the denial was issues, and to communicate any additional clinical information that may not have been included in the original request. Additionally, in certain circumstances an eQHealth Physician Reviewer may reach out to the ordering physician in order to conduct a P2P to discuss an authorization request prior to an adverse determination. Additional information regarding this process is available in the ***Peer to Peer Consultation Guide***.

IMPORTANT CONTACT INFORMATION

HCPF and eQHealth Solutions are committed to delivering exceptional customer service. There are a variety of ways to efficiently obtain information and assistance.

Checking the status of a previously submitted authorization is available 24 hours per day, seven days per week by logging into eQSuite®. Questions may also be submitted in eQSuite® using the secure online helpline module.

For all inquiries that cannot be addressed through eQSuite:

The toll-free customer service number is: 1-888-801-9355. Staff are available 8:00AM – 5:00PM Mountain Standard Time, Monday through Friday, excluding the following State-observed holidays:

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- President's Day
- Memorial Day
- Labor Day
- Thanksgiving Day
- Martin Luther King Day
- Independence Day
- Veterans Day
- Christmas Day
- Columbus Day

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.

In addition to customer service, eQHealth Provider Relations staff are also available to assist during regular business hours and can be reached via email at ***co.pr@eqhs.org***.

For additional information, concerns or questions regarding HCPF policy, please contact HCPF Utilization Management staff at ***hcpf_hospitalreview@state.co.us***.