

# Adverse Determinations and Reconsideration/Reassessment Process

## General Education Session August 18-19, 2010

### Presentation Overview

- What is an Adverse Determination?
  - Examples of adverse determinations
- Adverse Determination Notifications/Letters
- Reconsideration Process
  - Reconsideration
  - Reassessment
- When Not to Request a Reconsideration
- Summary with Q&A

#### Adverse Determination

- An adverse determination is a general term used for any unfavorable utilization or coding finding.
- Only a physician reviewer can render an adverse determination.

#### **Adverse Determinations**

- Examples of adverse determinations rendered by a physician reviewer include:
  - Medical necessity denial
    - The denial is issued based on the clinical information and can include the admission or length of stay.
  - Change in DRG
    - The billed principal or secondary diagnoses and/or procedural coding is inconsistent with the documentation in the medical record.

#### Adverse Determination Letters

 When an adverse determination is rendered, the hospital Medicaid liaison is notified.

#### **Types of Notices**

- Concurrent Review
  - Notice of Denial Certification Request
    - Admission or length of stay
  - Notice of Denial of Preoperative Day(s)
- Retrospective Prepayment Review
  - Notice of Admission Denial
  - Notice of Length of Stay Denial
  - Notice of Denial of Preoperative Day(s)
  - Change in DRG

#### Reconsideration Process

• When an eQHealth Physician Reviewer renders an adverse determination, the hospital or treating physician is afforded the opportunity to request a reconsideration.

**Reconsideration** of medical necessity denial; or **Reassessment** of a DRG change

#### Reconsideration Process

- Hospital Liaison Receives Notice of Denial
- Hospital or treating physician may request a reconsideration
  - The request must be in writing and:
    - Include request for peer-to-peer discussion; if needed
    - Include a copy of medical records for date(s) denied
    - Sent to eQHealth Solutions via fax or mail
      - Within 60 days of Notice of Denial
  - Two types of reconsideration
    - Expedited while patient is still hospitalized
    - Standard within 60 calendar days from the date of denial

eQHealth sends either a notice of receipt or notice of invalid request

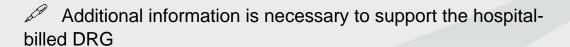
## Reconsideration Process (cont.)

- Reconsideration Review
  - Physician Review Determination
    - Determinations include:
      - Upheld (denial is upheld)
      - Modified (certification of some of the days; others denied)
      - Reversed (denial is reversed, the days requested are certified)
    - Determination is rendered within 30 calendar days from the receipt of all necessary information
  - Notice of Determination
    - Mailed to both Physician and Hospital

If a reconsideration is reversed, the hospital continues with the review process to certify additional days or submit a discharge review.

#### Reassessment of DRG

- Hospital Medicaid Liaison Receives a notice of DRG Change
- Hospital or treating physician may request a reassessment:
  - The request must be in writing and:
    - Include peer-to-peer request; if needed
    - Include a copy of medical records for date(s) denied
    - Sent to eQHealth Solutions via fax or mail



#### Reassessment of DRG

#### Reassessment Review

- Physician Review Determination
  - Determinations Include:
    - Upheld (determination upheld)
    - Modified (secondary diagnoses may be modified)
    - Reversed (back to the original, hospital-billed DRG)
  - Determination rendered within 30 calendar days from the receipt of all necessary information
- Notice of Reassessment of DRG
  - Mailed to both Physician and Hospital

#### When Not to Request Reconsideration

- A reconsideration should **not** be requested when:
  - The determination is an approval (certified)
  - eQHealth has not conducted a review
    - Claim rejection
  - A prepayment review is cancelled due to:
    - No medical record received; or
    - Incorrect billing
      - Incorrect admit or d/c date
      - Incorrect d/c status code
      - Incorrect category of service

## Reminder Regarding Third Parties

- Third Party Contractors
  - If your hospital contracts with an outside company for reconsiderations:
    - Third-party contractors may submit a request for reconsideration or reassessment on behalf of the hospital and submit information; however, all notifications and conversations will be directed to the designated hospital personnel and/or treating physician.
  - Hospitals were notified in a Provider Update dated May 10, 2010
    - il.eqhs.org

# Summary

Request for Reconsideration or Reassessment	Submission Requirements
Download forms from our Website:  il.eqhs.org  Click on the <i>Provider Resources</i> tab	The hospital or physician may submit a request, in writing, within 60 calendar days from the date of denial notice or the DRG change notice:
Fax or mail your request: Fax: 800-418-4039	✓ For reconsideration: Provide a copy of the medical record for date(s) denied or additional clinical information to substantiate medical necessity.
Mail: eQHealth Solutions Attn: Reconsideration	✓ For reassessment: Provide supporting documentation to validate billed DRG.
2050-10 Finley Road Lombard, IL 60148	✓ For peer-to-peer contact: Provide written request and contact information if you require peer-to-peer discussion.

#### eQHealth Solutions

Reconsideration Request Form for HFS Participants  PARTICIPANT INFORMATION	
PROVIDER	RINFORMATION
Hospital IL Medicaid #: Hospital Name:	Physician IL Medicaid #:
REQUEST INFORMATION	
Request Date:/  Request Method: □ Fax □ Mail	Requested By:    Hospital Physician  Requestor Name:  Requestor Telephone #: ()Ext
RECONSIDERATION INFORMATION	
	Date of Administrative Denial:/
Rationale/Medical Reason for Disagreement:	
Is additional information being submitted?   Yes  NOTE: If the denial determination was made on an Admiss Request, a copy of the medical record for date(s) of denial to	

An approved request for Certification of Admission and/or Continued Stay does not guarantee payment. When an approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service and to confirm the patient's continuing need for service.



## Q & A Session

- Please keep your phone on mute or noise level down to hear the Q & As.
- Phone lines are now open. State your name and hospital and your question.
  - We will compile Q&As from these sessions and post them to our Website for future use.

# Your Time Is Appreciated

- Your feedback is important to us.
  - An email will be sent with a link to a quick survey.
- Thank you for attending today's education session.
  - Visit our Website for valuable Provider Resources.