



Prior Authorization of Elective Procedures

Provider Manual

Effective Date March 1, 2014

for procedures on and after April 1, 2014

Table of Contents: Inpatient Review

- I. Getting Started – Request for Certification**
- II. Overview of Services**
 - A. eQHealth Solutions Overview and Contact Information**
 - B. Provider Services and Resources**
 - C. Hospital Contact Information**
 - D. Submitting Prior Authorization Requests**
 - E. Review Requests and Determinations**
 - F. Utilization Review Process**
 - G. Reconsideration Process**
 - H. Notifications of Review Outcome**
- III. HFS Attachment F – Procedures Subject to Review**
- IV. Forms and Instructions**
- V. Overview of eQSuite™ and Summary of Provider Reports**

I. Getting Started – Certification at a Glance

Healthcare and Family Services

IMPORTANT: Providers must read and be familiar with HFS' policies and procedures located at <http://www2.illinois.gov/hfs/MedicalProvider/Handbooks/Pages/default.aspx>. Before submitting any request to eQHealth, providers must check the Participant's Medicaid eligibility and service limit information through Healthcare and Family Services' eligibility verification channels.

➤ **Requests for Prior Authorization (PA) must be submitted to eQHealth Solutions with the following information**

- ✓ Participant name and 9-digit Medicaid ID number.
- ✓ Admitting physician (surgeon) 9-digit IL Medicaid ID and phone number
- ✓ The ICD9CM admitting diagnosis code
- ✓ The ICD9CM procedure code associated with CPT codes
- ✓ The hospital's 12-digit IL Medicaid Provider ID where participant will have procedure performed
- ✓ Clinical information related to proposed procedure

To assist hospitals, a template is available for surgeon (office) to provide you with information needed for utilization review. The templates are available in Section IV of this document.

- **Prior authorization review is strictly for certification (prior authorization) of specific procedures. This is not an inpatient admission (concurrent) review.**
- **Prior authorization is required regardless of reimbursement type (DRG or Per Diem).**
- If the request is approved, the approval is valid for a 60-day period from the date of the QIO's approval letter. If the surgery cannot be completed within the 60-day timeframe; the patient is admitted to another hospital; or the planned procedure code changes, the hospital must submit a new request for prior authorization via eQSuite™.

II. Overview of Services

A. eQHealth Solutions – Illinois' Quality Improvement Organization

eQHealth Solutions, Inc. (eQHealth), under contract to Healthcare and Family Services (HFS) since 2002, serves as Illinois' Quality Improvement Organization (QIO). eQHealth's role is to evaluate the medical necessity and quality of acute inpatient services for HFS fee-for-service participants. Dedicated to continuous quality improvement, eQHealth offers educational services for HFS medical program providers to support these activities.

eQHealth is contracted by HFS to perform concurrent admission and continued stay review, quality of care screening (during and after hospitalization), retrospective prepayment review (after discharge and prior to payment to the hospital), post-payment review (after discharge and payment to the hospital) and Prior Authorization of specific procedures 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 Sections 412.82 and 412.84.

eQHealth Contact Information

The table below lists phone and fax numbers and eQHealth business operation hours.

Purpose	Description	Hours of Operation and Number(s)
Review Request Submission for Prior Authorization of Elective Procedure	Used by providers to submit review request and additional clinical information requested by eQHealth. Reviews submitted after 5 p.m. will be stamped as the next business day.	Web reviews: http://il.eqhs.org Click on “eQSuite” button to access. 24 hours/day, 7days/week Log in granted from hospital-assigned eQSuite™ Web Administrator
Requests for Reconsideration of Medical Necessity Denial	Used by providers to submit requests for medical necessity denials.	Toll-free Fax: (800) 418-4039 Use PA Reconsideration Request Form (must be for Prior Authorization)
Dedicated Fax Line	Used by providers to submit requests for prior authorization (when no computer access) and fax their requests for reconsideration.	Toll-free Fax: (800) 418-4039 Faxes are handled during regular business hours 8 a.m. to 5 p.m. Monday - Friday, not including holidays.
Provider Helpline	Assistance with review procedures, status updates, change requests, general information.	Toll free: (800) 418-4045 8 a.m. to 5 p.m., CST on business days, except State holidays. Online Helpline: http://il.eqhs.org Log in to “eQSuite” to access, 24 hours/day, 7days/week
eQSuite™	Secure, HIPAA-compliant online system to submit requests, check status, view notifications, etc.	Click on eQSuite™ button from eQHealth homepage at http://il.eqhs.org
Business Address	If you want to submit any information in writing, please mail it to us.	eQHealth Solutions, Inc. Illinois Division 2050-10 Finley Road Lombard, IL 60148

B. Provider Services and Resources

eQHealth offers many free resources to help you obtain the information or assistance you need to meet the review requirements for Prior Authorization:

Web-based Review System & Provider Reports

Requests for Prior Authorization are submitted to eQHealth Solutions through our proprietary Web system, eQSuite™. Registered users access eQSuite from our Web site at <http://il.eqhs.org>. The system is accessible 24 hours a day, seven days a week.

If your facility does not have an eQHealth Web Account, complete a Hospital Contact Form located under the “Quick Resources” section on our Website at <http://il.eqhs.org>. Each hospital must assign a Web Administrator to grant select users access to eQSuite™ to submit reviews, view letters and/or run reports.

When requesting a prior-authorization, Providers must take into consideration the following HFS-approved holidays that eQHealth is closed:

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

Provider Reports

Provider specific reports are also accessed through the “eQSuite” button on our Web site. Providers may use these reports to obtain real-time status or outcomes of reviews. Users may also access other Web features and send online helpline requests from this Web-based system. For more information about the individual Web reports available, visit the PriorAuthResources tab on our Web site homepage.

Free Web-based Training

eQHealth offers free training sessions to instruct hospitals how to use the Web-based review system and access provider-specific reports. Visit <http://il.eqhs.org> under the PriorAuthResources tab for a list of monthly classes.

Provider Communications & Resources

Providers have access to important information 24/7, on the eQHealth Website, by clicking on the PriorAuthResources tab.

- Provider Communications – eQHealth Provider Updates and HFS Informational Notices
- Frequently Asked Questions (FAQs)
- eQSuite™ Web User Guide
- Provider Forms - including Hospital Contact Form, Prior Authorization Template and Prior Authorization Reconsideration Request Form
- Training Presentations

C. Hospital Contact Information

Healthcare and Family Services Medicaid program requires vital communication with hospital personnel. It is important to have current contact information for the following members on the *Hospital Contact Form*:

Hospital CEO or CFO

The hospital CEO or CFO information is used as appropriate approval for assigning the eQHealth Liaison at each facility. This contact information may also be used in targeted communications.

Hospital CMO or Medical Director

The hospital CMO or Medical Director's contact information is used only for targeted communications. This is not a required field.

eQHealth Liaison

The eQHealth (Medicaid) Liaison is selected by 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 this liaison. It is important to keep the eQHealth Liaison contact information accurate to ensure all applicable information is received.

eQHealth Quality Contact

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.

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 is responsible for assigning access rights and maintaining log-in IDs for eQHealth Web users at their facility.

The *Hospital Contact Form* can be downloaded from our Website at <http://il.eqhs.org> under the Quick Resources section of our homepage.

D. Submitting Prior Authorization Requests

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

Thousands of healthcare professionals submit review requests and receive certification responses via the Web. eQHealth's HIPAA secure, Web-based system – eQSuite™ provides 24/7 access to:

- Submit review requests
- Check status of your Web submitted review
- Provide additional information when requested by eQHealth
- Submit online helpline queries
- View or print provider-specific notification/determination letters
- Run provider-specific reports with review data

For more information on the Web system, see Section V of this manual.

Web Administrator

The Web Administrator will have rights to create a Provider profile for each user to grant access to eQSuite™ and maintain User IDs and passwords.

If the hospital does not currently have a Web Administrator, you must appoint one. Managing system access and users is a non-technical process. A *Hospital Contact Form* is available on our Website.

E. Review Requests and Determination Timeframes

Description	Request Method	Requirements/Timeframe	Determination
<p><i>Mandatory prior authorization of non-emergent, CABG and back surgery procedures.</i></p> <p><u>Prior authorization is required for elective procedures subject to review on HFS Attachment F that are scheduled on and after April 1, 2014.</u></p>	<p>The hospital must obtain prior authorization of procedures subject to review by submitting requests online through eQHealth's Web system, eQSuite™.</p> <p><u>DO NOT send requests or inquiries to HFS.</u></p>	<p>Requests must be submitted to eQHealth via the Web:</p> <ul style="list-style-type: none"> • <u>Up to 30 calendar days prior to procedure date</u> • <u>No later than 3 business days prior to procedure date (more, if requested before a holiday).</u> 	<p>eQHealth will render a medical necessity determination in 2 business days from the receipt of all necessary information.</p> <p><i>A reconsideration of a medical necessity denial may be requested a) prior to the procedure date and b) requested no later than 10 calendar days from the date of the denial.</i></p>

IMPORTANT: The prior authorization number (TAN) will be valid for 60 calendar days from the date of the eQHealth approval notice:

- *If a TAN is issued and the admission date changes but remains within those 60 days, the hospital can change the admission date on eQSuite (Utility) or call the eQHealth Helpline with the new admission date. **The TAN is still valid.***
- *If the procedure is **rescheduled** outside of the 60 days, the hospital must submit a new request for Prior Authorization (at least 3 days prior to admission).*
- *If a TAN is issued and the procedure code changes the hospital must submit a new request for Prior Authorization (at least 3 days prior to admission date). Reminder: The procedure code must be listed on HFS Attachment F.*
- *If a TAN is issued and the procedure becomes emergent; the TAN for prior authorization is not needed for billing HFS. The hospital will proceed with requesting **inpatient Med/Surge** review with eQHealth if the admitting diagnosis is subject to review. The hospital will then bill HFS for an **emergency** procedure.*

F. Utilization Review Process

Requesting a Prior Authorization Online through eQSuite™

The hospital will click "Create a New Review" from the eQSuite™ menu options. Prior authorization of service(s) is also referred to as an "admission type" in eQSuite™. **On the Start tab, the user will select "Prior Authorization HFS Attachment F – Back" OR "Prior Authorization HFS Attachment F -CABG" as the Admission Type.** This will display the correct review screens for a Prior Authorization. See Section V of this manual for an overview of eQSuite™.

Healthcare and Family Services (HFS) Exceptions to Prior Authorization Review

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment occurred at the time of admission.
- Other – the hospital must provide narrative description.

Please contact a UB-04 Billing Consultant at HFS at 1-877-782-5565 if the hospital believes one of the above exceptions applies. Providers can download utilization review Attachments A through F from the Department's Website at <http://www2.illinois.gov/hfs/MedicalProvider/proqio/Pages/default.aspx>.

Review Process

First level (nurse) reviewers will use InterQual® procedural criteria to screen for medical necessity of the procedure. eQHealth will complete the review within two business days from receipt of all required documentation. The hospital, as well as the operating physician, will receive notification detailing approval, denial or additional information needed. Hospitals must receive approval prior to performing the procedure.

Hospitals will not be reimbursed without an approved procedure on file, for codes subject to prior authorization on HFS Attachment F.

The following table describes eQHealth staff functions:

Staff	Functions
First Level reviewers Utilization Review Coordinators (RNs)	<ul style="list-style-type: none">• Apply HFS approved medical necessity clinical guidelines.• May request additional information (See pended review section).• Approve procedure based on policy and application of criteria.• Refer requests to physician reviewer that cannot be approved at nurse level.
Second Level Reviewers (Physicians)	<ul style="list-style-type: none">• Make certification or denial determinations. The determination is:<ul style="list-style-type: none">○ Based on hospital documentation that supports medical necessity and appropriateness of setting.○ Sensitive to the local healthcare delivery system infrastructure.○ Based on the physician reviewer's clinical experience, judgment and generally accepted standards of healthcare.• Only physicians may render an adverse determination for medical necessity. <p>Note: See the <i>Reconsideration Process</i> section of this manual</p>

Pended Review for Additional Information

Review Type	If the review cannot proceed because ...	Then	Timeframe for submission
Prior Authorization of Elective Procedure	Clinical information is needed by the first level nurse reviewer to satisfy criteria.	The hospital Liaison is faxed a Request for Additional Information and status shown as pended on eQSuite™.	The hospital will supply additional information within 1 business day from the date on notice or the request will be canceled.

Submitting Additional Information

Prior Authorization requests may require additional information to help meet medical necessity:

- The hospital should check all Prior Authorization requests online within 24 hours of submission. The status will display as, at nurse, at physician or pend. For pending reviews, a notice of "Request for Additional Information" will be faxed to the hospital Liaison and is available for view online. You may submit the additional information needed through eQSuite™ under the *Request for Add'l Info* tab. Please download the eQSuite™ User Guide from our Web site. **All prior authorization information is available under the PriorAuthResources tab.**

G. Reconsideration Review Process

If the hospital or physician disagrees with the adverse determination made by eQHealth, a request for reconsideration may be submitted. The hospital or treating physician/clinician may request an expedited reconsideration request using the eQHealth Prior Authorization Reconsideration Request form (included in Section IV of this manual).

A second eQHealth physician reviewer, who is board certified, and not involved in the initial decision, will review the reconsideration request and make a determination. The following apply to reconsideration requests:

- a) If the reconsideration request is untimely with no good cause, a notice is sent that the request is invalid.
- b) Upon reconsideration review, if the denial is upheld a notice is sent and there is no other course of action from eQHealth.
- c) Upon reconsideration review, if the denial is reversed (approved) a notice is sent and the Treatment Authorization Number (TAN) is valid for 60 calendar days from the date of approval notice.

H. Notification of Review Outcome or Cancel

Outcome	Details
Prior Authorization Approval	<ul style="list-style-type: none">• A <i>Notice of Approval</i> is auto-faxed to both the eQHealth Liaison (hospital) and the operating physician.• Notices can be viewed or printed by the hospital from eQSuite™.
Pended for Additional Information	<ul style="list-style-type: none">• A <i>Notice of Request for Additional Information</i> is auto-faxed to the eQHealth Liaison (hospital) and physician (surgeon).• Notices can be viewed or printed by the hospital from eQSuite™.• The requested information must be submitted within 1 business day or eQHealth will cancel the request and the hospital must submit a new request.
Denial	<p>If eQHealth physician reviewer determines the procedure is not medically necessary, a denial letter will be issued and reconsideration rights will apply.</p> <ul style="list-style-type: none">• A <i>Notice of Denial</i> is auto-faxed to eQHealth Liaison (hospital) and physician (surgeon).• Notices can be viewed or printed by the hospital from eQSuite™.
Cancel	<p>A cancellation notice will be issued if the procedure code is not subject to review, is received less than 3 days prior to admission or Medicaid eligibility is not confirmed at time of request.</p> <ul style="list-style-type: none">• A <i>Notice of Cancelled Request</i> is auto-faxed to eQHealth Liaison (hospital) and physician (surgeon).• Notices can be viewed or printed by the hospital from eQSuite™.

III. HFS' ATTACHMENT F – CODES SUBJECT TO REVIEW

Procedure Codes Subject to Prior Authorization

The tables below list the ICD-9 procedure codes subject to prior authorization on HFS Attachment F:

ICD-9 Code	Beginning Review Date	HFS Attachment F Description
<i>Coronary Artery Bypass Surgery Codes for Prior Authorization</i>		
36.10	03/01/14	(Aorto)coronary bypass for heart revascularization, not otherwise specified
36.11	03/01/14	(Aorto)coronary bypass of one coronary artery
36.12	03/01/14	(Aorto)coronary bypass of two coronary arteries
36.13	03/01/14	(Aorto)coronary bypass of three coronary arteries
36.14	03/01/14	(Aorto)coronary bypass of four or more coronary arteries
36.15	03/01/14	Single internal mammary-coronary artery bypass. Anastomosis-single: mammary artery to coronary artery, thoracic artery to coronary artery
36.16	03/01/14	Double internal mammary-coronary artery bypass. Anastomosis, double: mammary artery to coronary artery, thoracic artery to coronary artery
36.17	03/01/14	Abdominal - coronary artery bypass. Anastomosis: Gastroepiploic - coronary artery
36.19	03/01/14	Other bypass anastomosis for heart revascularization
<i>Back Surgery Codes for Prior Authorization</i>		
80.50	03/01/14	Excision or destruction of intervertebral disc, unspecified
80.51	03/01/14	Excision of intervertebral disc
81.00	03/01/14	Spinal fusion, not otherwise specified
81.02	03/01/14	Other cervical fusion of the anterior column, anterior technique. Arthrodesis of C2 level or below: anterior interbody fusion, anterolateral technique
81.03	03/01/14	Other cervical fusion of the posterior column, posterior technique. Arthrodesis of C2 level or below, posterolateral technique
81.04	03/01/14	Dorsal and dorsolumbar fusion of the anterior column, anterior technique. Arthrodesis of thoracic or thoracolumbar region: anterior interbody fusion, anterolateral technique; Extracavitary technique
81.05	03/01/14	Dorsal and dorsolumbar fusion of the posterior column, posterior technique. Arthrodesis of thoracic or thoracolumbar region, posterolateral technique
81.06	03/01/14	Lumbar and lumbosacral fusion of the anterior column, anterior technique. Anterior lumbar interbody fusion (ALIF). Arthrodesis of lumbar or lumbosacral region: anterior interbody fusion, anterolateral technique, retroperitoneal, transperitoneal, Direct lateral interbody fusion [DLIF], Extreme lateral interbody fusion [XLIF]

<i>Back Surgery Codes for Prior Authorization (cont)</i>		
ICD-9 Code	Beginning Review Date	HFS Attachment F Description
81.07	03/01/14	Lumbar and lumbosacral fusion of the posterior column, posterior technique. Facet fusion. Posterolateral technique. Transverse process technique
81.08	03/01/14	Lumbar and lumbosacral fusion of the anterior column, posterior technique. Arthrodesis of lumbar or lumbosacral region, posterior interbody fusion. Axial lumbar interbody fusion [AxiaLIF]. Posterior lumbar interbody fusion (PLIF). Transforaminal lumbar interbody fusion (TLIF).
81.30	03/01/14	Refusion of spine, not otherwise specified
81.32	03/01/14	Refusion of other cervical spine, anterior column, anterior technique. Arthrodesis of C2 level or below: anterior interbody fusion, anterolateral technique
81.33	03/01/14	Refusion of other cervical spine, posterior column, posterior technique. Arthrodesis of C2 level or below, posterolateral technique
81.34	03/01/14	Refusion of dorsal and dorsolumbar spine, anterior column, anterior technique. Arthrodesis of thoracic or thoracolumbar region: anterior interbody fusion, anterolateral technique, Extracavitary technique
81.35	03/01/14	Refusion of dorsal and dorsolumbar spine, posterior column, posterior technique. Arthrodesis of thoracic or thoracolumbar region, posterolateral technique
81.36	03/01/14	Refusion of lumbar and lumbosacral spine, anterior column, anterior technique. Anterior lumbar interbody fusion (ALIF). Arthrodesis of lumbar or lumbosacral region: anterior interbody fusion, anterolateral technique, retroperitoneal, transperitoneal. Direct lateral interbody fusion [DLIF]. Extreme lateral interbody fusion [XLIF]
81.37	03/01/14	Refusion of lumbar and lumbosacral spine, posterior column, posterior technique. Facet fusion, Posterolateral technique, Transverse process technique
81.38	03/01/14	Refusion of lumbar and lumbosacral spine, anterior column, posterior technique. Arthrodesis of lumbar or lumbosacral region, posterior interbody fusion. Axial lumbar interbody fusion [AxiaLIF]. Posterior lumbar interbody fusion (PLIF). Transforaminal lumbar interbody fusion (TLIF)
81.39	03/01/14	Refusion of spine, not elsewhere classified
81.62	03/01/14	Fusion or refusion of 2-3 vertebrae
81.63	03/01/14	Fusion or refusion of 4-8 vertebrae
81.64	03/01/14	Fusion or refusion of 9 or more vertebrae
84.51	03/01/14	Insertion of interbody spinal fusion device. Insertion of: cages (carbon, ceramic, metal, plastic or titanium), interbody fusion cage, synthetic cages or spacers, threaded bone dowels
84.52	03/01/14	Insertion of recombinant bone morphogenetic protein rhBMP. That via collagen sponge, coral, ceramic and other carriers

IV. Forms and Instructions

- Prior Authorization Template– Communication with Surgeon - CABG
- Instructions for Prior Authorization Template - CABG
- Prior Authorization Template– Communication with Surgeon - Back
- Instructions for Prior Authorization Template - Back
- Request for Reconsideration Form (Prior Authorization)

Request Date: _____ Elective CABG	
MEDICAID PARTICIPANT INFORMATION	
Participant Name: Last, First, Middle _____ Date of Birth: □□/□□/□□	Medicaid ID #: □□□□□□□□ Sex: □ Age: □□□
HOSPITAL/REQUESTOR INFORMATION PHYSICIAN'S INFORMATION	
Hospital's Name: _____ Medicaid 12-Digit Provider ID #: □□□□□□□□□□□□ Requestor: _____ Phone #: (□□□) □□□-□□□□ Ext. □□□□ email: _____	<input type="checkbox"/> Attending(Surgeon) Physician's Name: Last, First, Middle Initial _____ Street Address: _____ City: _____ State: _____ Zip Code: □□□□□-□□□□ Phone #: (□□□) □□□-□□□□ Medicaid ID # □□□□□□□□

Participant Medicaid ID Number:

Elective CABG

Participant Last/First/Middle Name: _____ Date of Birth:

PREADMISSION INFORMATION

(Proposed) Admission date:

ICD-9-CM DIAGNOSIS CODE(S)	NARRATIVE DESCRIPTION(S)	
1.		
Scheduled Date	ICD-9-CM Procedure Code(s)	Procedure Description(s)
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

CLINICAL INDICATIONS

Stenosis in one or more vessels ☐ Yes ☐ No

If yes, vessels affected/percentage _____

Failed PCI ☐ Yes ☐ No

Graft(s) occluded ☐ Yes ☐ No

Coronary Artery Anomalies ☐ Yes ☐ No

Unstable angina ☐ Yes ☐ No If yes, still present with treatment ☐ Yes ☐ No

Diabetes Mellitus ☐ Yes ☐ No

Heart failure/Congestive Heart Failure ☐ Yes ☐ No If yes, is it newly diagnosed ☐ Yes ☐ No

PAST TREATMENTS

List results of any treatments not described in clinical indications section:

Participant Medicaid ID Number: Elective CABG

Participant Last/First/Middle Name: _____ Date of Birth: //

Labs/Studies/Tests(enter the date and results of pertinent labs, studies & tests)

Date- if available/applicable	Lab/Study/Test	Results/Findings
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Heart Catheterization	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	EKG	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	Stress Test	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

X-ray & Imaging(enter the date and results of x-rays and imaging)

Date- if available/applicable	X-Ray/Imaging	Results/Findings
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	ECHO	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	TEE	
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>		

Additional Comments: Please provide additional information needed to complete prior authorization review. It is **NOT** necessary to repeat information that was already provided in other sections of this form. Include a short clinical summary of the participants' pertinent history and progress.

P Participant Medicaid ID Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Elective CABG
Participant Last/First/Middle Name: _____ Date of Birth: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	

HEALTH CARE AND FAMILY SERVICES DISCLAIMER STATEMENT
eQHEALTH SOLUTION'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID
PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY
FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND
LIMITATIONS OF THE MEDICAID PROGRAM.

As an authorized Medicaid provider, I certify that I have reviewed the information submitted for prior authorization certify that the information provided is true, accurate, and complete to the best of my knowledge. I understand that services requested herein are subject to review and approval through Healthcare and Family Services' Utilization Management and Quality Improvement Organization. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or may disqualify me as a provider of Medicaid services.

 Signature of Requestor

 Date

INSTRUCTIONS FOR PRIOR AUTHORIZATION OF CABG

THIS INFORMATION MUST BE COMMUNICATED TO THE HOSPITAL FOR **ELECTIVE CABG**
ALL REQUESTS NEED TO BE SUBMITTED ONLINE BY THE HOSPITAL
AT LEAST THREE DAYS PRIOR TO ADMISSION

PARTICIPANT INFORMATION

- ▶ **Participant Name** - Enter the Participant's last, first and middle name as it appears on the IL Medicaid ID card.
- ▶ **Date of Birth** - Enter the month, date, and year of the Participant's birth.
- ▶ **Participant Medicaid Number** - Enter the Participant's nine (9) digit number that appears on the IL Medicaid identification card.
- ▶ **Sex** - Indicate the sex of the Participant.
- ▶ **Age** - Enter the age of the Participant at the time service is to be rendered.

HOSPITAL/REQUESTOR INFORMATION

- ▶ **Hospital's Name** - Enter the name of the hospital to which the Participant will be admitted.
- ▶ **Hospital IL Medicaid Provider Number** - Enter the hospital's Illinois Medicaid provider number.
- ▶ **Hospital Requestor's Name and Phone Number** - Enter the name of the individual requesting review and include telephone number with area code and extension.

ATTENDING (SURGEON) INFORMATION

- ▶ **Physician's Name** - Enter the name of the attending (surgeon) physician, last, first and middle initial.
- ▶ **Physician's Address** - Enter the street address, city, state and zip code of the physician.
- ▶ **Physician's Phone Number** - Enter the phone number of the physician.
- ▶ **Physician's Medicaid Number** - Enter the physician's Medicaid number.

PREADMISSION INFORMATION

- ▶ **(Proposed) Admission Date** - Enter the proposed date of admission for the procedure.
- ▶ **ICD-9-CM Diagnosis Code(s)** - Enter the ICD-9-CM code(s) and narrative description(s) for the Participant's primary diagnosis.
- ▶ **Date(s)/ICD-9-CM Code(s)/Procedure(s)** - Enter date of planned procedure(s), the ICD-9-CM procedure code(s) and procedure narrative description(s).

CLINICAL FINDINGS

- ▶ **Clinical Indications** - Mark the appropriate clinical indications for the planned procedure.

PAST TREATMENTS

- ▶ **Previous treatments** - List results of any treatments not described in clinical indications section.

LABS/STUDIES/TESTS/X-RAY/IMAGING

Enter date and results of pertinent labs, studies, tests, x-rays and imaging that may be necessary to complete prior authorization review.

SUMMARY

This is provided for communicating any additional information you believe will support that the planned procedure is medically necessary. **It is not necessary to repeat any information previously documented.**

Request Date: _____ Elective Back Surgery

PARTICIPANT INFORMATION

Participant Name: Last, First, Middle

Date of Birth: / /

Medicaid ID #:

Sex: Age:

HOSPITAL/REQUESTOR INFORMATION

Hospital's Name:

Medicaid 12-digit Provider ID #:

Hospital Requestor Name:

Phone #: () -

Ext.

email:

PHYSICIAN'S INFORMATION

☐ Attending(Surgeon)

Physician's Name: Last, First, Middle Initial

Street Address: _____

City: _____

State: _____

Zip Code: -

Phone #: () -

Medicaid ID #

Participant Last/First/Middle Name: _____ Date of Birth: ____/____/____

(Proposed) Admission date: / /

NARRATIVE DESCRIPTION(S)

1.

Procedure Description(s)

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

		/			/		
--	--	---	--	--	---	--	--

CLINICAL INDICATIONS

CLINICAL INDICATIONS

Pain/paresthesia/numbness ☐ Yes ☐ No If yes, explain _____

Extremity weakness ☐ Yes ☐ No If yes, affected extremity(s) _____

Motor/sensory deficit ☐ Yes ☐ No If yes, explain _____

Radiculopathy ☐ Yes ☐ No If yes, explain _____

Bladder/bowel dysfunction ☐ Yes ☐ No If yes, explain _____

Decreased rectal sphincter tone ☐ Yes ☐ No

Activity Modification ☐ Yes ☐ No If yes, date(s)/duration_____

Formal Physical Therapy program ☐ Yes ☐ No If yes, date(s)/duration_____

Pain with ADL's ☐ Yes ☐ No If yes, explain_____

Intractable pain, despite oral analgesic tx. ☐ Yes ☐ No If yes, explain_____

NSAID's ☐ Yes ☐ No If yes, duration/outcome _____

Epidural injections ☐ Yes ☐ No If yes, date(s)/outcome_____

Congenital anomalies of the cervical, thoracic, lumbar area or spinal cord ☐ Yes ☐ No

Participant Medicaid ID Number:

Elective Back Surgery

Participant Last/First/Middle Name: _____ Date of Birth:

PAST TREATMENTS

List results of any treatments not described in clinical indications section:

Labs/Studies/Tests(enter the date and results of pertinent labs, studies & tests)

Date- if available/applicable	Labs/studies/tests	Results/Findings
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	EMG	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Participant Medicaid ID Number:

Elective Back Surgery

Participant Last/First/Middle Name: _____ Date of Birth: **X-Rays/Imaging(enter the date and results of X-rays & Imaging)**

Date- if available/applicable	X-rays/Imaging	Results/Findings
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CT	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	CT-MYL	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MRI	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	X-ray:	
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Additional Comments: Please provide additional information needed to complete prior authorization review. It is **NOT** necessary to repeat information that was already provided in other sections of this form. Include a short clinical summary of the participants' pertinent history and progress.

HEALTH CARE AND FAMILY SERVICES DISCLAIMER STATEMENT

eQHEALTH SOLUTION'S CERTIFICATION DETERMINATION DOES NOT GUARANTEE MEDICAID PAYMENT FOR SERVICES OR THE AMOUNT OF PAYMENT FOR MEDICAID SERVICES. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

As an authorized Medicaid provider, I certify that I have reviewed the information submitted for prior authorization. I certify that the information provided is true, accurate, and complete to the best of my knowledge. I understand that services requested herein are subject to review and approval through Healthcare and Family Services' Utilization Management and Quality Improvement Organization. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or may disqualify me as a provider of Medicaid services.

Signature of Requestor_____
Date

INSTRUCTIONS FOR PRIOR AUTHORIZATION OF BACK SURGERIES

THIS INFORMATION MUST BE COMMUNICATED TO THE HOSPITAL FOR **ELECTIVE BACK SURGERY**
ALL REQUESTS NEED TO BE SUBMITTED ONLINE BY THE HOSPITAL
AT LEAST THREE DAYS PRIOR TO ADMISSION

REQUEST DATE

- ▶ **Request Date** - Enter the date of submission of the request.

PARTICIPANT INFORMATION

- ▶ **Participant Name** - Enter the Participant's last, first and middle name as it appears on the IL Medicaid ID card.
- ▶ **Date of Birth** - Enter the month, date, and year of the Participant's birth.
- ▶ **Participant Medicaid Number** - Enter the Participant's nine (9) digit number that appears on the IL Medicaid identification card.
- ▶ **Sex** - Indicate the sex of the Participant.
- ▶ **Age** - Enter the age of the Participant at the time service is to be rendered.

HOSPITAL/REQUESTOR INFORMATION

- ▶ **Hospital's Name** - Enter the name of the hospital to which the Participant will be admitted.
- ▶ **Hospital IL Medicaid Provider Number** - Enter the hospital's Illinois Medicaid provider number.
- ▶ **Hospital Requestor's Name and Phone Number** - Enter the name of the individual completing the review form and include telephone number with area code and extension.

ATTENDING (SURGEON) INFORMATION

- ▶ **Physician's Name** - Enter the name of the attending (surgeon) physician, last, first and middle initial.
- ▶ **Physician's Address** - Enter the street address, city, state and zip code of the physician.
- ▶ **Physician's Phone Number** - Enter the phone number of the physician.
- ▶ **Physician's Fax Number** - Enter the fax number of the physician.
- ▶ **Physician's Medicaid Number** - Enter the physician's Medicaid number.

PREADMISSION INFORMATION

- ▶ **(Proposed) Admit Date** - Enter the proposed date of admission for the procedure.
- ▶ **ICD-9-CM Diagnosis Code(s)** - Enter the ICD-9-CM code(s) and narrative description(s) for the Participant's primary diagnosis.
- ▶ **Date(s)/ICD-9-CM Code(s)/Procedure(s)** - Enter date of planned procedure(s), the ICD-9-CM procedure code(s) and procedure narrative description(s).

CLINICAL FINDINGS

- ▶ **Clinical Indications** - Mark the appropriate clinical indications for the planned procedure.

PAST TREATMENTS

- ▶ **Previous treatments** - List results of any treatments not described in clinical indications section.

LABS/STUDIES/TESTS/X-RAY/IMAGING

Enter date and results of pertinent labs, studies, tests, x-rays and imaging that may be necessary to complete prior authorization review.

ADDITIONAL COMMENTS

Additional space is provided for provision of any additional information you believe will support that the planned procedure is medically necessary. **It is not necessary to repeat any information previously documented.**

Reconsideration Request Form for Prior Authorization

RECONSIDERATION TYPE:	<i>EXPEDITED- Prior authorization</i>	<input type="checkbox"/> CABG <input type="checkbox"/> Back Surgery
------------------------------	--	--

PARTICIPANT INFORMATION

Recipient ID # (RIN):		Sex		Age		Date of Birth:		
Participant Name:				xx/xx/xxxx				
	(First)	(MI)	(Last)					

PROVIDER INFORMATION

Hospital Medicaid ID:		Attending(Surgeon) Physician Medicaid #:	
Hospital Name:		Attending(Surgeon) Physician Name:	
			(First) (MI) (Last)

Physician Contact Requested? ☐ Yes ☐ No

If "Yes", provide Treating Physician Information: (no third party contact)	Name: Phone Number:
---	------------------------

REQUEST INFORMATION

Request Date:		Requested By:		Hospital		Physician
Request Method:		Fax		Mail		
Fax: 1-800-418-4039, Attn: Denial/Reconsideration	Requestor Name:					
Mail: eQHealth Solutions, 2050-10 Finley Rd., Lombard, IL 60148	Requestor Telephone #:					
Attn: Denial/Reconsideration Coordinator						

RECONSIDERATION INFORMATION

Date of Denial Notification:	
Date of Admission:	

Rationale / Medical Reason for Disagreement (type in text box below):

IMPORTANT: Please complete this form and submit it with additional information or documentation to support the medical necessity of the procedure(s).

An approved request for Prior Authorization does not guarantee payment from HFS. When an approval is given, it is the provider's responsibility to verify the patient's eligibility for that service.

INSTRUCTIONS

COMPLETING THE EQHEALTH SOLUTIONS RECONSIDERATION REQUEST FORM FOR PRIOR AUTHORIZATION OF ELECTIVE PROCEDURES

Section I: Participant Information

- ▶ **Recipient Identification #** – Enter the Participant's number that appears on the IL Medicaid identification card.
- ▶ **Participant Name** – Enter the Participant's first name, middle initial, and last name as it appears on the IL Medicaid identification card.
- ▶ **Sex** – Indicate the sex of the Participant.
- ▶ **Age** – Enter the age of the Participant at the time service (is to be) was rendered.
- ▶ **Date of Birth** – Enter the month, date, and year of the Participant's birth. Use two-digit numbers, e.g., 01/04/64.

Section II: Provider Information

- ▶ **Hospital IL Medicaid #** – Enter the hospital's Illinois Medicaid provider number.
- ▶ **Hospital Name** – Enter the name of the hospital that (will render) rendered the treatment.
- ▶ **Physician IL Medicaid #** – Enter the physician's Illinois Medicaid provider number.
- ▶ **Physician Name** – Enter the first name, middle initial, and last name of the attending (Surgeon) physician.

Section III: Request Information

- ▶ **Request Date** – Record the date of the request.
- ▶ **Request Method** – Indicate whether request submitted by fax, mail or telephone.
- ▶ **Requested By** – Indicate whether the physician or hospital made the request.
- ▶ **Requestor Name** – Enter the name of the individual requesting the review.
- ▶ **Requestor Telephone #** – Enter the telephone number of the requestor including area code.

Section IV: Reconsideration Information

- ▶ **Date of Denial Notification** – Enter the date medical necessity denial letter was issued.
- ▶ **Date of Admission** – Enter the date the patient was admitted to the hospital.
- ▶ **Rationale for Request** – Enter the medical basis/rationale for disagreement.
- ▶ **Additional information submitted** – Indicate whether additional information is submitted with the request.

V. Overview of eQSuite™ and Summary of Provider Reports

eQSuite™ Overview

Key features of eQSuite™ include:

- Secure HIPAA-compliant technology allowing providers to record and transmit information necessary for review
- Secure transmission protocols including the including encryption of all data transferred
- System access control for changing or adding authorized users
- 24x7 access with easy to follow data entry screens
- Rules-driven functionality and system edits to assist Providers through immediate alerts such as when a review is not required or a field requires information.
- A reporting module that provides real-time status of all review requests.
- A helpline module for Providers to submit questions about a particular request.

Minimal system requirements:

- Computer with Intel Pentium 4 or higher CPU and monitor
- Windows XP SP2 or higher
- 1 GB free hard drive space
- 512 MB memory
- Broadband Internet connection

IMPORTANT: eQSuite™ requires Internet browsers that support HTML5 as well as the latest W3C standards. The current version and the two *prior* major releases of any of the following browsers are supported:

- Chrome
- Firefox
- Internet Explorer
- Safari

The following browsers and their predecessors are no longer supported:

Firefox 3.5, IE 7, and Safari 3

Summary of Provider Reports

The report inquiry feature allows hospitals to obtain real-time status of eQHealth Solutions reviews. There are 25 unique reports available through eQSuite™. **Providers will use the following reports specific for Prior Authorization.**

- RPT: 1 Review Status/Outcome for a Given Participant (enter patient's Medicaid #)
- RPT: 2 Status of All In-Process Certification Reviews (*at nurse, pending, at physician*)
- RPT: 3 Assigned TANs (Prior Auth Certifications) in Admission Date Range
- RPT: 8 Initially Denied Reviews, Reconsiderations in Process and all Completed Outcomes
- RPT: 13 Reviews Pending for Additional Information (*must respond in 24 hours/1 business day*)
- RPT: 15 Unreviewable Reviews Requests
- RPT: 17 Print Out of Web Review Request

IMPORTANT: Data displayed is considered confidential to the facility and must be treated as such by users who are authorized to access this module. Your hospital-assigned eQHealth Web Administrator will determine who may access the report inquiry module by creating a user profile and assigning a secure user name and password.