Colorado Inpatient Hospital Review Program

Introduction 3
Health First Colorado 3
Health First Colorado Providers 3
eQHealth Solutions 3
The ColoradoPAR Program 3
Introduction to the Inpatient Hospital Review Program (IHRP) 4
Inpatient Hospital Review Program Components 5
Inpatient Hospital Review Policy 5

Glossary 12

INTRODUCTION

HEALTH FIRST COLORADO

Health First Colorado (Colorado's Medicaid Program) aims to improve health care access and outcomes for the people served while demonstrating sound stewardship of financial resources. Health First Colorado serves as the primary insurance for pregnant women, low income children and adults, the elderly, and residents living with disabilities. The Colorado Department of Health Care Policy and Financing (HCPF) oversees and manages Health First Colorado.

EQHEALTH SOLUTIONS

eQHealth Solutions is a non-profit, multi-state health care quality improvement, medical cost management and health information technology company and is the contracted vendor for Health First Colorado's Utilization Management (UM) program, administering the Inpatient Hospital Review Program (IHRP) and the ColoradoPAR program.

THE COLORADOPAR PROGRAM

ColoradoPAR is Health First Colorado's UM program. eQHealth Solutions has been contracted with the Department to provide utilization review services for the ColoradoPAR program since September 1, 2015. Together, eQHealth and the Department work to serve Medicaid members and providers by implementing the Department's mission to improve health care access and outcomes for our members while demonstrating sound stewardship of financial resources.

- Adult Long-Term Home Health (71/2019)
- Audiology
- Diagnostic imaging
- Durable medical equipment (DME)
- Habilitative Speech Therapy - Adult
- Inpatient Admissions
- Inpatient out-of-state admissions
- Long-Term Support Services (Waivers)
- Medical services including transplant and bariatric surgery
- Physical & Occupational therapy
- Molecular Testing
- Pediatric Behavioral Therapy
- Pediatric Long-Term Home Health (LTHH)
- Pediatric Personal Care Services
- Physical and Occupational Therapy
- Private duty nursing
- Speech Therapy (4/1/2019)
- Surgeries (outpatient and inpatient)
- Synagis®

To date, the ColoradoPAR Program reviews Prior Authorization Requests (PARs) for the following services and supplies:

The Department recognizes the need to continually improve the efficiency and effectiveness of Health First Colorado programs. Cost containment and care coordination have been a priority of the state for some time, and in the spring of 2018 Senate Bill 18-266, entitled: 'Controlling Medicaid Costs', passed through the Colorado House and Senate with unanimous support. The bill enables the Department to control costs more effectively within Health First Colorado, Child Health Plan Plus (CHP+) and its other public health programs and initiatives.[1].

In March 2019, in accordance with the Senate Bill 18-266, inpatient hospital stays will require authorization. Section 2 of the guide will detail the processes and policies for inpatient authorization requests being submitted through the eQSuite® portal.

INTRODUCTION TO THE INPATIENT HOSPITAL REVIEW PROGRAM (IHRP)

As a result of SB 18-266, the Department was directed to design and implement an evidenced-based, inpatient hospital review program. The Inpatient Hospital Review Program is effective March 18, 2019 when Providers will begin submitting reviews to eQHealth Solutions. To allow for a period of transition, reviews will be required for payment processing as of May 15, 2019.

The objective of the program is to meet the medical needs of Medicaid members, and provide improved data to all of Colorado's ***Regional Accountable Entities*** (RAEs). Additional information on admissions will allow the RAEs to better coordinate and managed the member's care after discharge to improve quality and decrease readmission risk. The goals of the program include:

- Improve members' quality of care
- Facilitate better care planning and inpatient care transitions
- Ensure appropriate hospitalizations
- Improve service utilization
- Improve coding accuracy

- Provide timely, accurate information to the Department's partners who can directly assist members with highest needs

INPATIENT HOSPITAL REVIEW PROGRAM COMPONENTS

The review processes include the following components:

- **Preadmission/Prior Authorization Reviews** for inpatient hospital admissions including preauthorization for planned, elective, non-urgent/emergent, holiday or weekend admissions with guidance on length of stay and care settings
- **Continued Stay Reviews** for all authorized admissions with greater than a four-day length of stay
- **Complex Case Reviews** to be completed at day four for a specific subset of admitting diagnoses
  - **Neonates**
  - **Sepsis & Disseminated Infection**
  - **Respiratory Failure**
  - **Pneumonia**
- The Inpatient Hospital Review Program will consider certain factors in any determination, including:
- Information provided, diagnosis and treatment recommended by the treating provider(s);
- Policy Requirements, including benefit coverage, as set forth by the Department
- Evidence-based clinical coverage criteria, which relies on nationally accepted clinical standards that align with national practice guidelines; and
- Nationally recognized utilization and technology assessment guidelines and industry standard criteria as appropriate, based on a comprehensive literature review of the clinical evidence.

INPATIENT HOSPITAL REVIEW POLICY

Health First Colorado Member Eligibility

It is the responsibility of the providers, and their organization to verify Medicaid eligibility of each member to determine if authorization is required. If the member has a pending application, or becomes eligible for Colorado Medicaid retroactively, a Retrospective Authorization will be required.

Medicaid As Secondary Payer

Some Health First Colorado members may have additional coverage through Medicare or private insurance of some type. Health First Colorado is always the payer of last resort, however if the member has other insurance that will cover the services provided, an authorization through Health First Colorado is not needed. If the primary insurance coverage does not cover the services provided, authorization from Health First Colorado will be required. If coverage of the primary insurance is unknown, an authorization for Health First Colorado should be obtained in accordance with the submission timeframes of the Inpatient Hospital Review Program.

Emergency Medicaid

For those members with Emergency Medicaid, acute inpatient hospital admissions will require authorization. If the member is not eligible for Emergency Medicaid at the time of admission, but becomes eligible during the admission or after discharge, a Retrospective Review for the inpatient admission will be required.

Managed Care

Some members of Health First Colorado are assigned to a Managed Care Organization, such as Rocky Mountain Health Plans Prime or Denver Health Medicaid Choice eQHealth does not review authorization requests for members enrolled in a managed care plan which is determined through the eligibility verification process. If the member is enrolled with a managed care organization (MCO), providers will need to contact the MCO for authorization.

Behavioral Health Admissions

Inpatient Behavioral health does not require authorization through eQHealth Solutions. However, all acute inpatient admissions for emergency behavioral health services and/or stabilization do require authorization via eQHealth.

- If a recipient is not assigned a RAE at the time of admission, the request would be submitted to eQHealth Solutions
- If the RAE determines it is not covered by them, a review may be submitted retroactively to eQHealth Solutions for review

**Provide a summary within the review, under clinical summary, when submitting to eQHealth Solutions as to which of the above situation applies to the particular PAR request.

Rehabilitation Facilities

Designated stand-alone Rehabilitation Facilities (that do not provide acute inpatient services) will not be required to obtain authorization for services. This includes independent rehabilitation programs such as substance abuse and detox programs.

For all other rehabilitation services performed within the hospital setting, these will require a prior authorization. If transferring to a rehabilitation floor within the current facility-no new PAR is required (current PAR will still be in effect). All acute inpatient admissions, unless otherwise exempt from the IHRP, will require admission authorization and Concurrent Review. For a list of excluded rehabilitation facilities please visit this ***website***.

Maternity Admissions

Maternity admissions related to labor and delivery will not require authorization, including admissions for pre-term labor without delivery. If a member is pregnant and admitted to the hospital for a condition unrelated to the pregnancy, authorization will be required. For a list of all services that will not require a PAR please view the list ***here***.

Exceptions: "**Healthy Babies**" if you have a newborn that is not covered under the mother's insurance, these requests do require a PAR.

- A review must be submitted utilizing the Temp ID for the baby which will generate a Review ID number to be reviewed for medical necessity
- If needed, once the permanent Medicaid ID number is assigned to the baby, the provider may go into eQ Suites and utilize the "Utility" function to change the ID number for that recipient to generate a PAR

  "**NICU Babies**" that are not discharged with mother will require a PAR as well
- If Mother's insurance covers the newborn stay, then the date of service will be the date of Mother's discharge
- If Mother's insurance does **not** cover the newborn stay, then the date of service will be date of birth.

Pre-Admission/Prior Authorization Review

Some planned surgical procedures require Prior Authorization regardless of the setting. For these procedures a separate authorization request will be required for the procedure itself and can be submitted via eQ Suites. The authorization for the surgery itself will be entered by the referring physician's office prior to scheduling the surgery and/or procedure. If the surgery is approved and cannot be performed in an outpatient setting, an **additional authorization** request will be required for the inpatient admission. Information regarding surgical procedures that require Prior Authorization can be found on the current ***Health First Colorado Fee Schedule***.

All pre-planned or elective inpatient hospital admissions require prior authorization. These requests can be requested/entered by the surgeon or by the inpatient hospital (at least two (2) Business Days prior to the admission) in order to obtain a determination.

Admission Review

Admission authorizations are required for all unscheduled, non-maternity related inpatient admissions. Examples include, but are not limited to:

- Unscheduled direct or non-urgent admission
  - Admission authorization requests should be entered within one (1) Business Day of admission to an inpatient facility
- Urgent/Emergency admission
  - Requests should be submitted to eQHealth for review within one (1) Business Day upon stabilization of an emergent condition as defined by the ***Emergency Medical Treatment & Labor Act***, ""EMTALA reg at 42 USCS § 1395dd, "(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."
- Neonates admitted following discharge of the mother
- Status change reflecting inpatient status

eQSuite® is available for authorization submission twenty-four (24) hours per day, seven (7) days a week for provider convenience, but authorization requests are not required to be entered after hours, on weekends or state holidays. eQHealth Solutions and the Department are available Monday through Friday, 8:00am-5:00 pm (MST) except for state 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.

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 the member is hospitalized or at post discharge. A Retrospective authorization will be required as soon as the inpatient facility becomes aware of the member's eligibility.

A provider may, under certain circumstances, request an authorization to be reviewed retrospectively. In these cases, eQHealth Solutions will work with the provider to determine the appropriateness of the request and will consult with the Department for approval on a case by case basis. Provider should enter an explanation within the review, under the clinical summary section, as to why this review was entered retrospectively.

Continued Stay Review

Continued Stay Reviews are required when an Admission Review has been approved and the member remains in the hospital at day four (4) overnight following the admission.

These requests will be submitted at day four (4) of the member's hospitalization. A Provider should submit documentation that supports the hospital stay for Day 4. Day one (1) is considered the day that the member is admitted to an inpatient setting, and a Concurrent Review would be entered on day four (4) if the member remains admitted as 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 (4) for members admitted with diagnoses in the following categories:

- Neonates
- Sepsis
- Respiratory Failure
- Pneumonia

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 on Day 1 and Day 4
- Appropriate initiation of discharge planning if applicable
- eQHealth may request additional information as part of the review for those inpatient admissions that fall under the Complex Case designation.

***Please ensure the level of care on Day 1 and Day 4 is noted within the review upon submission

REVIEW COMPLETION TIMEFRAMES

eQHealth's timeframe for completing a review are outlined below. The completion time is measured from the time all required information is received by eQHealth.

Type of Review	Review Completion Timeframes
Pre-Admission/Prior Authorization	Within 1 Business Day
- Nurse reviewer determination	Within 1 Business Day
- When referred to a physician reviewer	Within 1 Business Day
Concurrent/Continued Stay (at day 4 review)	Within 1 Business Day
Complex Case Review	Within 4 Business Days
Standard Reconsideration	Within 10 Calendar Days

***Notification of determination will be given within 4 business days of final decision under reconsideration

If an authorization request is submitted without the necessary supporting documentation, the provider will be notified and allowed one (1) Business Day to upload or fax the required clinical documentation. If the documentation is not received within one (1) Business Day, the request will be pended back to the provider a second time to request the supporting documentation. If supporting documents are not received within 1.5 Business Days from the second pend request, the authorization will be denied for lack of information.

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. 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** denial occurs when an eQHealth physician determines that the information submitted does not substantiate the Medical Necessity of the service requested. Medical Necessity denials will be reviewed by Department staff to ensure the appropriateness of the determination.

A **Reconsideration** request may be submitted within 10 calendar days of an adverse determination and any additional information may be submitted for review during the Reconsideration process. Examples of additional information may 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

You may request a Reconsideration in eQ Suites under the reconsideration tab. 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 Primary Physician Reviewer.

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 and how to request one, please see the ***Reconsideration Provider Guide***.

PEER TO PEER CONSULTATIONS

Peer to peer (P2P) consultations offer the ordering physician (requesting the inpatient admission) the opportunity to discuss a Medical Necessity denial determination with an eQHealth physician reviewer following the initial adverse determination. Provider has 5 calendar days to request the Peer to Peer from the date the adverse determination was made. 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 issued, 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 and discuss an authorization request prior to issuing an adverse determination. Additional information regarding this process is available in the ***Peer to Peer Consultation Guide***.

INPATIENT HOSPITAL REVIEW PROGRAM RESOURCES

The ***ColoradoPAR*** website offers a wealth of information and training resources including:

- Educational webinars
- How to Guides for eQSuite®
- How to Guide for the ***Inpatient Training Portal***
- Frequently Asked Questions
- Forms and Instructions
- Links to Colorado Medicaid billing manuals, provider bulletins and fee schedules

IMPORTANT CONTACT INFORMATION

The Department and eQHealth Solutions are committed to delivering exceptional customer service. There are a variety of ways to obtain information and assistance:

- Checking the status of a previously submitted authorization is available twenty-four (24) hours per day, seven (7) 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 holidays:

- New Year's Day
- President's Day
- Memorial Day
- Martin Luther King Day
- Independence Day
- Veterans Day

- Labor Day
- Christmas Day
- Thanksgiving 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.com***.
- For additional information regarding Health First Colorado Inpatient Hospital information, please review the ***Health First Colorado Billing manuals***, including the ***Inpatient/Outpatient Billing Manual***.
- For additional information, concerns or questions regarding HCPF policy please contact HCPF Utilization Management staff at ***HCPF_UM@State.co.us***

Acronyms, Abbreviations and Other Terminology

Admission Review- Medical appropriateness review for unplanned, urgent, or emergent admissions entered within 1 Business Day of admission or stabilization of the member.

Attending Physician- A licensed physician who would normally be expected to certify ore recertify the Medical Necessity for the services rendered and who has primary responsibility for the member's medical care and treatment.

Business Day- Any day in which the Department of Health Care Policy & Financing is open and conducting business but shall not include weekend days or any day on which a State approved holiday is approved.

Business Hours- 8:00 a.m. – 5:00 p.m. Mountain Time (MST) each Business Day.

Complex Case Reviews- In-depth clinical reviews performed for an identified subset of diagnosis codes at day four of an inpatient hospital admission to ensure the appropriate level of care is being rendered.

Continued Stay Review- Reviews conducted while the member is currently inpatient at day four.

Department/HCPF- The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado that administers Colorado Medicaid.

Expedited Reconsideration- A Reconsideration that must be completed expeditiously due to the risk of life or limb of the member.

Inpatient Hospital Review Program (IHRP)- The Department's evidence-based hospital review program created in SB 18-266 "Controlling Medicaid Costs" to ensure appropriate utilization of hospital services.

Medical Necessity- Medical Necessity as defined by Colorado Rule 10 CCR 2505-10 8.076.1.8.

Ordering Provider- The Physician, Nurse Practitioner or Physician's Assistant who prescribes the requested care for the member.

Pre-Admission/Prior Authorization Review (PAR)- A prospective review for an inpatient admission that must be obtain before services are rendered.

Reconsideration- The process by which a provider can request a re-review of a denial determination.

Rendering Provider- The facility, company or person who renders care to the member.

Regional Accountable Entity (RAE)- A single regional entity responsible for implementing the Accountable Care Collaboration within its region.

Retrospective Review- The process of determining coverage for a clinical service by applying criteria to support services after the opportunity for Prior Authorization or Concurrent Review has passed and the services have already been provided.

Technical Denial- The denial of an authorization request due to missing, inadequate, or incorrect information or the request does not meet the policy requirements of the Department.