

# Health First Colorado Utilization Review

Speech Therapy  
Utilization Review

## Introduction to eQHealth Solutions:

- *24-hour access for Utilization Review submissions*
- *Provider Communication and Support*
- *Provider Education and Outreach*
- *Comprehensive Utilization Management Program*
  - Prior Authorization Review (PAR)
  - Retrospective Review
  - PAR Reconsiderations & Peer-To-Peer Reviews
  - PAR Revisions
  - Real time access to provider reports

# Current Scope of Services

- Diagnostic Imaging
- Durable Medical Equipment
- Physical & Occupational Therapy
- Medical
  - Transplants
  - Surgical Procedures: such as Bariatric surgery
- Molecular Testing - BRCA1 and BRCA2
- Inpatient
- Pediatric Behavioral Therapy
- **Speech Therapy**
- Pediatric Long-Term Home Health
- Private Duty Nursing
- PASRR
- Out of State Non-emergency Inpatient Stays
- Audiology
- Synagis<sup>®</sup>
- Vision

# Important Medicaid Rules to reference:

- [Colorado Medicaid Rule 8.076.1.8 \(All Services Except DME\)](#) - *Outlines Definition of Medical Necessity*
- [Colorado Medicaid Rule 8.590.2.A \(DME ONLY\)](#) - *DME, Supplies and Prosthetic or Orthotic Devices are a benefit when Medically Necessary*
- [Colorado Medicaid Rule 8.200.2.D.1](#) - *The Speech-Language and Hearing Services Benefit Coverage*

# Connectivity to eQSuite®

## Minimal Computer System Requirements

- ❖ Any one of the following browsers (please note it must be one of the two most recent versions):
  - Internet Explorer
  - Google Chrome
  - Mozilla Firefox
  - Safari
  
- ❖ Broadband internet connection
  
- ❖ Technical Issues

<http://www.coloradopar.com/ProviderResources/ITRequirements.aspx>

# Getting Started

# eQSuite® Access



## New Users:

You will need to complete and submit an access form.  
 You can locate this form on our website  
[www.coloradopar.com](http://www.coloradopar.com)

*(Once received and entered you will receive an email confirmation with your username and password)*

## System Administrator:

- ✓ The person assigned will be responsible keeping all user accounts updated. *(Email address/phone numbers etc.)*
- ✓ You will have the ability to create additional User Accounts.
- ✓ Keeping all users informed of any updates or notifications sent from eQHealth.
- ✓ Please note that the Service Setting is a drop-down menu where you can make your selection

## eQSuite® Access Form

Complete and submit this form to obtain System Administrator Access to eQSuite® for your Group/Practice. Once we create User Access for your provider group the System Administrator will be able to create and manage additional eQSuite® user accounts for your staff.

Please Type in the Fillable Fields and email this form to

[CO.PR@EQHS.COM](mailto:CO.PR@EQHS.COM) or Fax: 866-940-4288

Providers Information	
<i>Access is granted based off of your Provider Type</i>	
<b>System Administrator First and Last Name</b>	Please Type in your name here
<b>Group/Practice Name</b>	
<b>NPI #</b>	
<b>Billing Medicaid ID#</b>	
<b>Phone #</b>	
<b>Email Address</b>	
<b>Service Setting</b>	Please Select Setting.. <ul style="list-style-type: none"> <li>Please Select Setting..</li> <li>Audiology</li> <li>Behavioral Therapy</li> <li>Diagnostic Imaging</li> <li>DME</li> <li>Long Term Home Health</li> <li>Long Term Support Services</li> <li>Medical Services</li> <li>Molecular Testing</li> <li>PASRR</li> </ul>
<p><b>IMPORTANT</b>                      (Please Read)</p> <p><b>UNAUTHORIZED ACCESS</b>                      By signing this form, you are attesting to the sole purpose of conducting Utilization Management for the individual to whom it assigned. Unauthorized use or improper use of the eQSuite® product may result in disciplinary action, as well as civil and criminal penalties.</p>	

# eQSuite<sup>®</sup> User Administration

If you are the System Administrator, you have the ability to create additional user accounts for your staff.

Log into eQSuite and click on “User Administration”

Click “Add New User”

- You will create a unique username/password for the employee and complete the fields.
- Check all of the applicable boxes, these will allow/restrict specific functions within eQSuite.

Once complete click “Save Changes”

*Inactive Date: This field should only be completed if you wish to inactivate/terminate an account for an employee.*

	UserID	User Name	Inactive DT	Phone	Extension	Added DT	Last Edit DT	Email
<a href="#">Edit</a>	90621	inptrainer		8009999992	9992	11/8/2018 12:00:00 AM	4/15/2019 9:24:19 AM	
<a href="#">Edit</a>	90628	coinpatient				3/20/2019 12:00:00 AM	3/20/2019 10:59:24 AM	
<a href="#">Edit</a>	90657	inpatienttrainer		1601382053		3/26/2019 11:40:28 AM	3/26/2019 11:41:19 AM	

User Edit

User Name:

First Name:

Last Name:

Password:

Email:

InactiveDate:

Phone Number:  -  -

Extension:

Branch Provider:

Allow to run reports:

Allow to enter requests:

Allow to view provider letters:

Allow to view physician letters:

Choose a status to receive email for:

Pended for Info

LOI

At Recon

Administrative Hold

Awaiting Required Attachments

Approved

Partially Denied

Denied

Recon Completed

[Save Changes](#) [Back to User List](#)



# Obtaining an Authorization

- Obtaining an authorization number is required when the item or service code requires an authorization and to verify whether the service requires prior authorization [here](#) before submitting a Utilization Review via eQSuite®.
- VERIFY the Client's eligibility for CO Medicaid (by contacting [Colorado Medicaid](#)).
- *Reminder: Authorization does not guarantee Medicaid payment for services.*

# Speech Therapy CPT Codes that require a PAR

[Health First Colorado Fee Schedule \(Click Here\)](#)

CPT Code	Description
92507	Treatment of speech, language, voice, communication and/or auditory disorder; individual.
92508	Treatment of speech, language, voice, or communication, and/or auditory processing disorder, group, 2 or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding.
92609	Therapeutic services for the use of speech-generating device, including programming and modification
97129	Therapeutic interventions that focus on cognitive function - direct (one-on-one) patient contact; initial 15 minutes.
97130	Therapeutic interventions that focus on cognitive function - direct (one-on-one) patient contact; each additional 15 minutes.

# Required Billing and PAR Modifiers

Outpatient Therapy Type	Modifier 1	Modifier 2
Rehabilitative Speech Therapy	GN	97
Habilitative Speech Therapy	GN	96
Early Intervention Speech Therapy	GN	TL

# Habilitative vs Rehabilitative

## Rehabilitative Speech Therapy

*Treats Acute Injuries and illness which are non-chronic conditions. Rehabilitative is therefore short-term in nature.*

- Rehabilitative speech therapy is a covered benefit for Medicaid members regardless of age

## Habilitative Speech Therapy

*Services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado Essential Health Benefits Benchmark plan.*

- Habilitative speech therapy is a covered benefit for all Medicaid members age 0-20
- Habilitative speech therapy is a covered benefit for Medicaid expansion members age 21 and over receiving benefits through the Alternative Benefits Plan (APB)

# Review Completion Timelines

Submission	Review Completion Timeframe
Prior to service	Standard - 4 business days
Untimely submission -anytime after the start of services	Within 4 business days of HCPF's Retroactive PAR exception decision
Retrospective - client was not eligible at the time of service  <i>**Providers have 1 year from retrospective eligibility to submit any Retrospective requests**</i>	4 business days

# Timeline for Retroactive PARs

Review Type	Retroactive PAR requests	PAR date range (calendar days)
Audiology	Are not accepted*	Up to 1 year (365 days)
Behavioral Therapy	Are not accepted*	Up to 180 days
Diagnostic Imaging	Are not accepted*	Up to 90 days
DME	Are allowed up to 90 calendar days	Up to 1 year (365 days)
Speech Therapy	Are not accepted*	Up to 180 days
LTHH	Are allowed up to 10 business days	Up to 1 year (365 days)
Inpatient	N/A	N/A
Molecular Testing	Are allowed up to 7 business days	Up to 1 year (365 days)
Private Duty Nursing	Are allowed up to 10 business days	Up to 1 year (365 days)
PT/ OT	Are allowed up to 2 business days	Up to 1 year (365 days)
Surgical	Are not accepted*	Up to 90 days
Transplants	Are not accepted*	Up to 1 year (365 days)
Vision	Are not accepted*	Up to 1 year (365 days)
PASRR	N/A	N/A

\* Exceptions for Retro: Emergencies, Provider/member eligibility concerns that prevented a timely PAR or exception requested by a provider can be granted by the Dept on a case by case basis.

# PAR Submission

## PAR request Receipt Dates:

- On business days:
  - From 12:00 a.m. - 5:00 p.m. (MST) - it is considered received that day.  
*Exception: Diagnostic Imaging Requests From 12:00 a.m. - 11:59 p.m. (MST) - it is considered received that day.*
- On holidays - it is considered received on the next business day.
- On days following state approved closures, i.e., natural disasters - it is considered received on the next business day.

# Supporting Documentation

## Referrals/Prescription/Orders

All Outpatient ST services must have a written referral/prescription/order/signed current therapy POC by any of the following:

- Physician (M.D or D.O)
- Physicians Assistant
- Nurse Practitioner
- Individualized Family Service Plan (IFSP) for Early Intervention Speech Therapy

## **PAR Requests Must Include:**

- Legibly written and signed ordering practitioner prescription, to include diagnosis (preferably with ICD-10 code) and reason for therapy, the number of requested therapy sessions per week and total duration of therapy.
- The member's speech therapy treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Current treatment diagnosis.
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical necessity for the course and duration of treatment being requested.
- Assessment or progress notes submitted for documentation, must not be more than sixty (60) days prior to submission of PAR request.



# First Level Clinical Review Determinations



First Level Clinical (Nurse) Reviewers may:



Approve the service as requested based on Department approved criteria.



Pend for Additional Information- when a PAR is pended back to the requesting provider for additional or clarifying information, the requesting provider will receive an eQSuite® email.



Refer the request to a physician reviewer for further review and determination (2<sup>nd</sup> level Clinical Review).



Deny the request for non-compliance with HCPF policy for Technical reasons, they can NOT deny for medical necessity.

# Second Level Clinical Review



*Second Level Clinical (Physician) Reviewers may:*



*Approve the service(s) as requested.*



*Pend: the review for additional information*



*Request for a peer-to-peer consultation with the ordering Provider.*



*Render an adverse determination. An adverse determination may be a full or partial denial of the requested services or a reduction in services.*

# Creating a New Review

# Definitions of Review Types

- ❖ **Admission - (Initial PAR request)** - Select this review type for a new/initial PAR request.  
*Please note: Admission is the terminology in eQSuite® for a new/initial PAR request and does not indicate a hospital inpatient admission. The review type "admission" should be used for most PARs submitted through eQSuite®.*
- ❖ **Cont Stay - (Continuation of Services)**-Select this review type to request a continuation of services, once the initial certification is going to end.  
*You will need the initial PAR #*
- ❖ **Modify Authorization - (PAR Revision)** - Select this review type when there is a clinical need to increase or decrease units in a active approved PAR or to add a new service code within the same "from" and "thru" dates to an existing eQHealth PAR.  
*You will need the PAR # for the review you wish to modify*
- ❖ **Retrospective** - Select this review type if the client received retroactive Medicaid eligibility for the DOS being requested. Providers have 1 year from retrospective eligibility to submit any Retrospective requests.

# Creating a New Review

Click "Create New Review"

The requesting provider will be pre-populated with your Provider Information

You will Check Yes/No if you are the Billing Provider. If you are not the Billing provider, you will enter the Medicaid ID# for the Billing Provider

Choose Setting: Outpt PT/OT/ST

Specify Type: ST

Review Type: Admission, Cont Stay, Modify Auth, Retrospective. Please see previous slide for review type definitions

Click Retrieve Data

The screenshot shows the 'Review Entry' web application interface. The top navigation bar includes the following links: 'Create New Review' (circled), 'Respond to Add'l Info', 'Respond to Denial', 'Online Helpline', 'Utilities', 'Reports', 'Search', and 'Attachments'. Below the navigation bar is a 'Review Entry' header. The main content area is divided into sections: 'Review Header Information' (Provider #: 999999992, Provider Name: INPATIENT PROVIDER), 'Review Type and Settings' (Requesting Provider ID: 999999992, Requesting Provider NPI: 9999999920, Requesting Provider Name: INPATIENT PROVIDER, Billing Provider ID: 999999992, Billing Provider NPI: 9999999920, Billing Provider Name: INPATIENT PROVIDER, Choose Setting: Surg/Nonsurg,  Outpt PT/OT/ST or CRT Eval, Outpt Mol Testing, Outpt Diag Imaging, DME - Orthotics, Immunization - Synagis, Behav Therapy, Specify Type: PT, OT,  ST, CRT Evaluation/Assessment, Review Type: Admission, eQHealth PAR Number: [empty], and a 'RETRIEVE DATA' button).

# Create a New Review-Start Tab

Enter the Client ID, once you hit enter the Name/DOB and Gender will auto populate

Physicians and HealthCare Practitioners:  
You will be required to enter the "Ordering Provider"

Click "Edit" and enter the Medicaid ID# for the Ordering Physician

Select the Type of Request "Urgent/Non-Urgent"

Enter the Start of Care (Start date of services)

If this is a Prior Auth Request enter the Proposed DC Date. If the services have been done enter the actual DC date.

Intended Place of Services: Select the appropriate place of service

Start

Client ID:  Name:  DOB:  Sex:

**If the patient is a baby and:**

- Has a personal Medicaid number, then enter this number in the Recipient ID box above.
- Otherwise, click the [Create Temp Baby ID] button and create a temporary Medicaid number. The system will enter the baby's name and birth date below.

Physicians and Healthcare Practitioners

	Type	Medicaid #
<a href="#">Edit</a>	Therapist	
<a href="#">Edit</a>	Ordering Provider	

Select type of request:

Start of care:

Proposed D/C Date:

Actual D/C Date:

Intended Place of Service:

# Create New Review-Start Tab

Once you select the place of service, you will be prompted to answer a series of questions you will need to check Yes/No

Once complete click "CHECK KEY"

*Once you click on CHECK KEY, if there are any errors with your entry you will receive a Check Key Error, see next slide.*

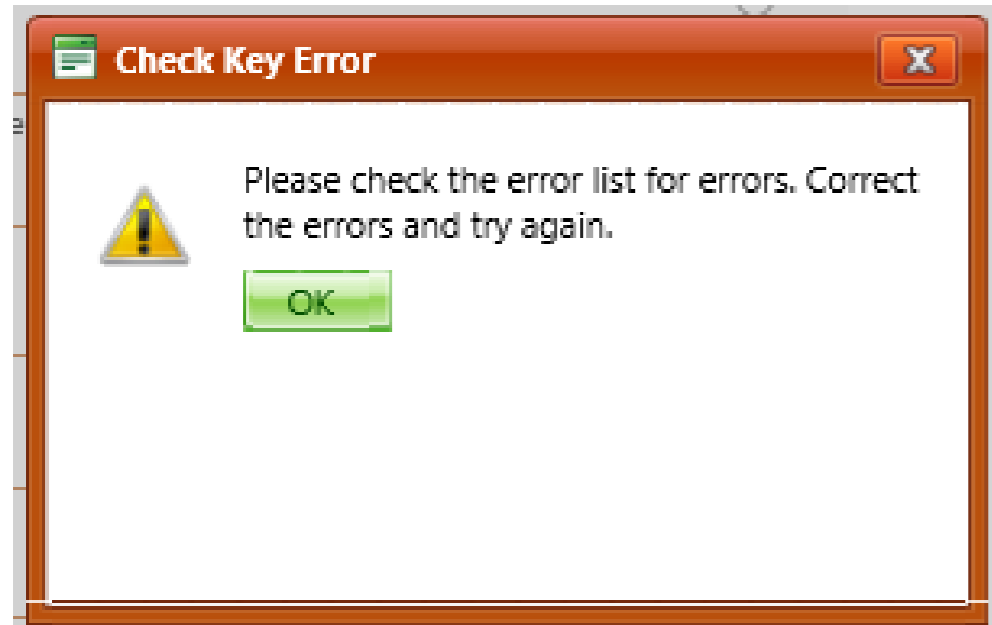
The screenshot shows a 'Start' tab form with the following questions and radio button options:

- Are services necessary solely due to environment? (No, Yes)
- Are services necessary solely due to convenience? (No, Yes)
- Are services necessary solely due to lack of transportation? (No, Yes)
- Did the client receive eligibility for Medicaid after some of the requested services were provided? (No, Yes)
- Did the client receive eligibility for Medicaid after all of the requested services were provided? (No, Yes)
- Are the requested services experimental or investigational? (No, Yes)
- For Hospice enrolled patients: Are the requested services related to the treatment of the terminal illness or associated condition? If no, explain on the Summary Tab. (No, Yes)
- Is this an EPSDT service? (No, Yes)
- Is this an Early Intervention Service? (No, Yes)
- Untimely PAR request? If yes, explain on the Summary Tab. (No, Yes)

At the bottom of the form are two buttons: 'CHECK KEY' and 'CANCEL'. An arrow points to the 'CHECK KEY' button.

# Checking for Errors

You will receive a pop-up box that will advise you to check for errors. Click on **OK**:



In the left-hand corner you will click on the Error Tab and it will display what needs to be fixed. Once you have made the corrections click on "Check Key" again.



# DX/PROC Tab-Entering the DX Codes

- Click on Add and enter the DX Code. You will need to enter the code without the decimal point.
- When you enter the code the Date Identified will auto populate with the start date of service you entered.
- Once you have entered the DX Code click on Add.
- Once you have completed entering the DX codes you can click on close to exit the screen.

The screenshot shows a web application interface with a tab labeled "DX CODES/ITEMS" which is highlighted with a red underline. Below the tab is a dark grey header bar containing an "Add" button (circled in black) and a "Search" button. Underneath the header is a table with two columns: "P" and "ICD Code". The table is currently empty, with the text "No records to display." centered below it.

The screenshot shows a dialog box titled "DX Code Add/Edit Page" with standard window controls (minimize, maximize, close). Inside the dialog, there are two input fields: "Code:" with the value "F840" and "Date Identified:" with the value "1/3/2016". Below the "Code:" field, the text "AUTISTIC DISORDER" is displayed. At the bottom of the dialog, there are two buttons: "Add" and "Close". A blue arrow points from the left towards the "Add" button.

# DX/Proc Tab-Entering the CPT Codes

Start | DX CODES/ITEMS | Clinical Info | SUMMARY

Add					Search		Refresh	
P	ICD Code	Description						
Y	R279	LACK COORDINATION NOS			<a href="#">Edit</a>	<a href="#">Delete</a>		

No records to display.

Click on the Add Button to enter the CPT Code

Add												Refresh	
Code	Modifier1	Modifier2	Modifier3	Description	From Date	Thru Date	Total Units	Units/Visit	Visits/Period	Period Type	# Periods		
92507	GO			Treatment of speech, language, voice, communication and/or auditory disorder; individual.	02/07/2019	02/01/2020	40	2	1	Week	20	<a href="#">Edit</a>	<a href="#">Delete</a>

CANCEL | PARTIAL SAVE | CONTINUE

# Entering the CPT Code

- Enter the CPT Code
- Enter the applicable modifier

**From/Thru Date= Authorization Date Span**

**From:** You will enter the Start date of care.

**Thru:** You will enter the anticipated DC Date

**Note:** You can request 180 Days for ST Services, use the Date Calculator to calculate your date range

*Units/Visit=1 Unit =15 minutes*

*Visits/Periods=How many visits within the Period Type you select*

*Period Type=Select from Drop Down*

*# of Periods=How many Days/Weeks that fall within the date range you entered.*

*Total Units will automatically Calculate  
Then click Add*

Code:	<input type="text" value="92507"/>
Description:	Treatment of speech, language, voice, communication and/or auditory disorder; individual.
Modifier:	<input type="text" value="GO"/>
Modifier 2:	<input type="text" value="(Select Modifier)"/>
Modifier 3:	<input type="text" value="(Select Modifier)"/>
From Date:	<input type="text" value="6/15/2020"/>
Thru Date:	<input type="text" value="12/11/2020"/>
<a href="#">Date Calculator</a>	
Units/Visit:	<input type="text" value="2"/>
Visits/Period:	<input type="text" value="2"/>
Period Type:	<input type="text" value="Week"/>
# Periods:	<input type="text" value="26"/>
Total Units:	<input type="text" value="104"/>
<a href="#">Add</a> <a href="#">Close</a>	

# Clinical Tab

**Clinical Info:** You will be prompted to answer clinical questions

You will need to answer the questions to the best of your ability. All questions marked with an \* are required.

Once you have answered the questions you will click on "Continue"

The screenshot shows a software interface with a navigation bar at the top containing four tabs: 'Start', 'DX CODES/ITEMS', 'Clinical Info', and 'SUMMARY'. The 'Clinical Info' tab is selected and highlighted with a red underline. Below the navigation bar is a table with three columns: 'Question', 'Yes/No', and 'Check all that apply'. The table contains a section titled 'CPT Codes' with the question 'How many visits per week are being requested?'. The table has six rows with options: '1', '2', '3', '4', '5', and '6 or more'. Each row has a corresponding 'Yes/No' column and a 'Check all that apply' column with a checkbox. Below the table is a text box containing the reminder: 'REMINDER: the physician's order must be on file and readily available if requested'. At the bottom of the interface are three buttons: 'CANCEL', 'PARTIAL SAVE', and 'CONTINUE'. An arrow points from the 'CONTINUE' button to the text box above it.

Question	Yes/No	Check all that apply
<b>CPT Codes</b>		
How many visits per week are being requested?		
1		<input type="checkbox"/>
2		<input type="checkbox"/>
3		<input type="checkbox"/>
4		<input type="checkbox"/>
5		<input type="checkbox"/>
6 or more		<input type="checkbox"/>

REMINDER: the physician's order must be on file and readily available if requested

CANCEL PARTIAL SAVE CONTINUE

# Summary Tab

The summary tab will allow you to enter in any additional information you deem pertinent to the request. You do not have to enter anything in this box.

Do not copy and paste into the box

Once you click on submit, a Review ID # will generate, you will want to keep this ID for your records

You will also be prompted to "Link Attachments" you will need to either upload the supporting clinical documentation or print a coversheet to fac over the documents.

The screenshot shows a web application interface with a navigation bar at the top containing tabs: Start, DX CODES/ITEMS, Clinical Info, and SUMMARY. The SUMMARY tab is active. Below the navigation bar is a text area with the following instructions: "Provide additional information to support the medical necessity of the PAR request in the following field. All required supporting documentation and/or documents as described in the Durable Medical Equipment and Supplies Provider Manual must be submitted with this PAR request, e.g. questionnaires, quotes or invoices, specialty evaluations, etc. Explain the reason for untimely submission of the PAR request, when applicable." Below this text area is a large empty text box for input. At the bottom of the form, there are three buttons: CANCEL, PARTIAL SAVE, and SUBMIT FOR REVIEW. The SUBMIT FOR REVIEW button is circled in black. Above the buttons, there is a red text warning: "By clicking [Submit for Review] you are attesting to the above." Above the warning is a blue link: "COLORADO DEPARTMENT OF HEALTHCARE POLICY AND FINANCING DISCLAIMER STATEMENT". Below the disclaimer is a small text note: "Please be aware that an eQHealth Solutions certification determination does not guarantee Medicaid payment for services."

The screenshot shows a web application interface with a navigation bar at the top containing buttons: Create New Review, Respond to Add'l Info, and Respond. Below the navigation bar is a header section with the word "Home". Below the header is a success message: "'Successfully submitted to eQHS for review.'" Below the message are three lines of text: "Review ID: [redacted]", "Bene Name: [redacted]", and "Bene ID: [redacted]". A green arrow points to the Review ID field. Below the text is a button labeled "Link Attachment". On the left side of the page, there is a vertical menu with the words "Menu" and "Errors".

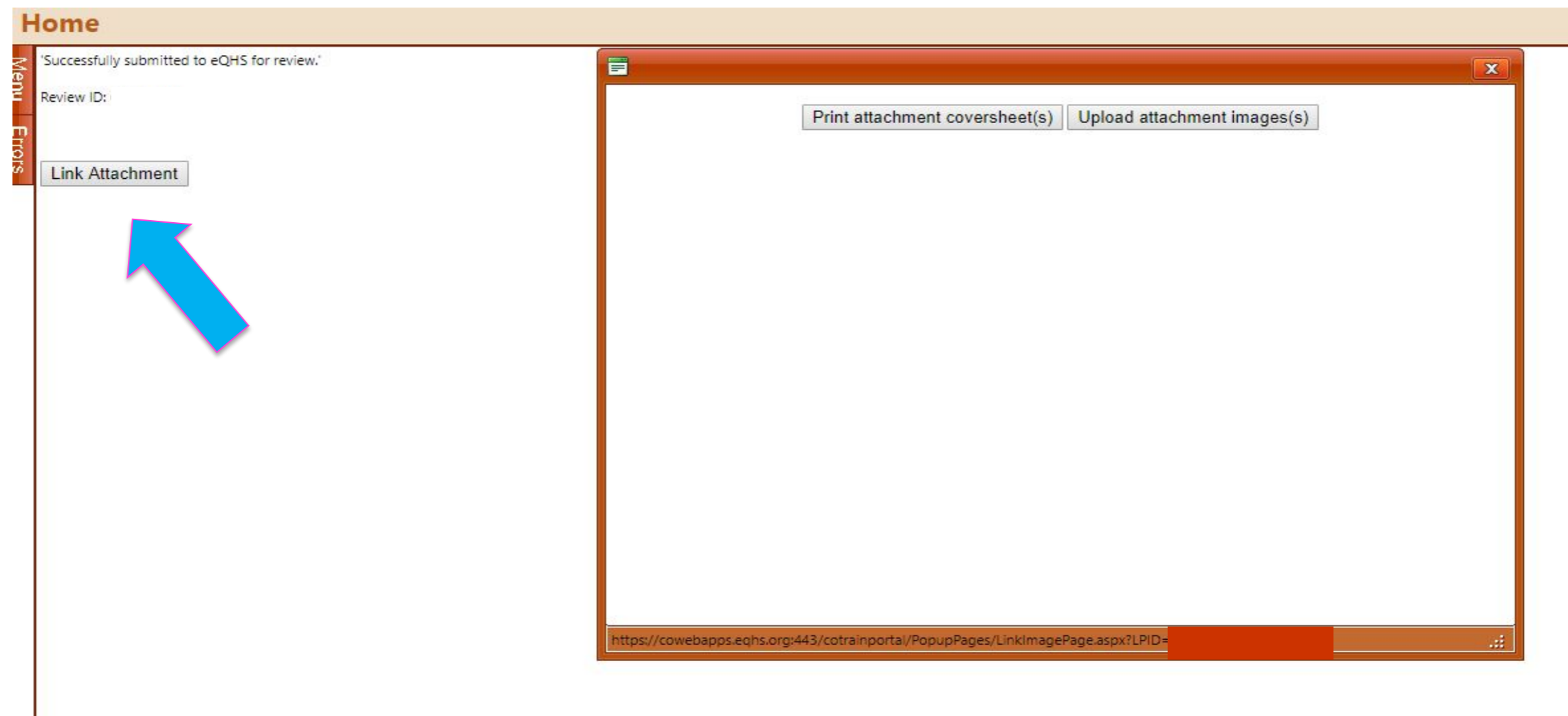
# Supporting Documentation

## Linking Attachments

Before proceeding, make sure that all requested documents are saved to your computer and available to upload in PDF, JPEG or TIF format.\*\*

Please reference our Guide on how to Submit Supporting Documentation

[ColoradoPar.com](http://ColoradoPar.com)



# Intermediate Statuses

Awaiting Supporting Documents	We have not received the clinical supporting documents
At Nurse Review	The request is currently being reviewed by a first level clinical nurse reviewer.
At PR Review	The request is currently being reviewed by a physician.
Pended for Add'l Info	Additional information is being requested from our clinical team. Please make sure to review the pend completely. There may be more than one item that is being requested from the reviewer.

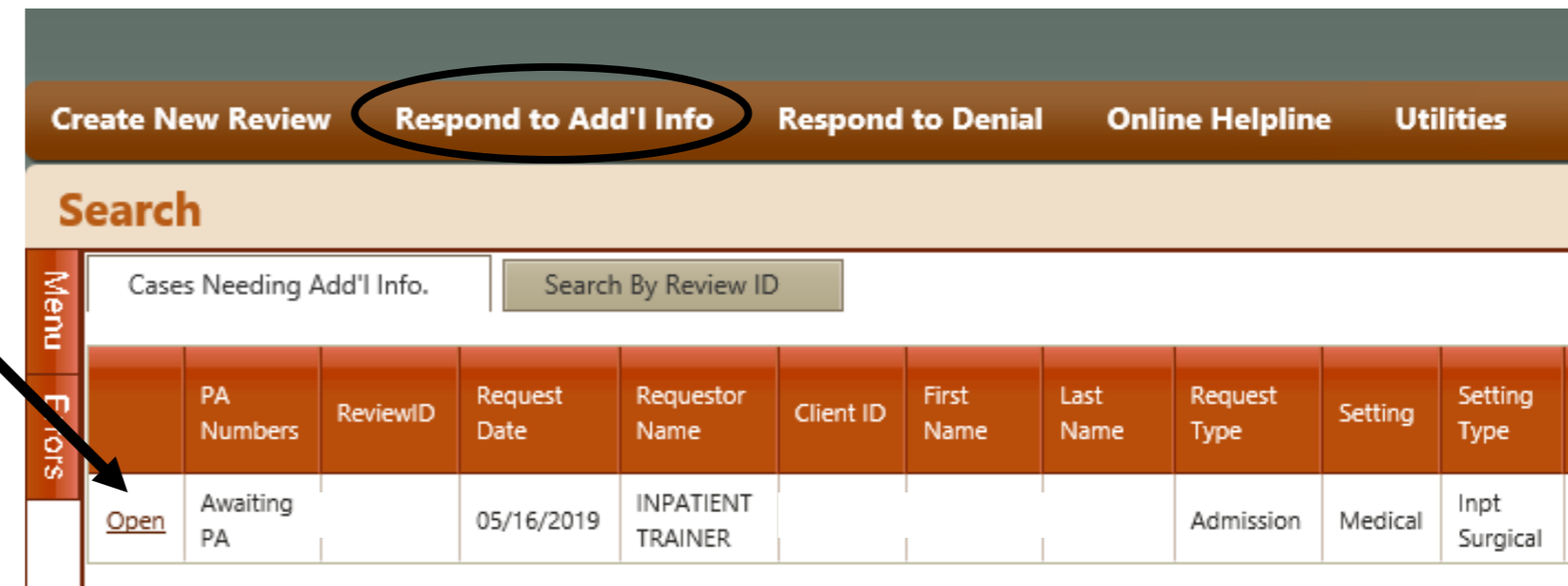
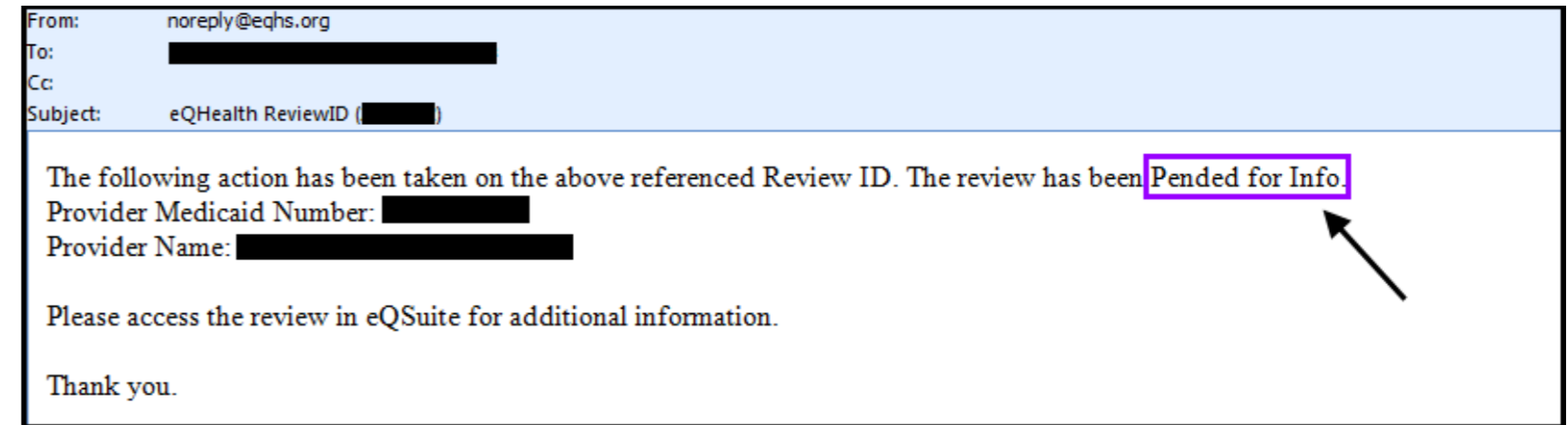
# Pended for Info

Once you have submitted your authorization request if the nurse needs additional information or if no documentation was received the review will be "Pended for Info"

You will receive an email notification referencing the review ID#

You will need to log into eQSuite® and click on "Respond to Add'l Info" and click "Open" to view/respond to the request

You will have 10 business days (from the date the utilization review is set to the status of "Pended for Add'l Info") to upload the requested documentation or respond to the request. If the requested documentation is not received within the 10 business days, your request will receive a *technical denial* for Lack of information (LOI) and both you and the Member will receive a denial notification.





# Responding to Pended Info request

In the Question Box you will see what is being requested from our clinical team.

You can type in a response in the “Additional Info” box

Once you click on “Submit Info” you will be prompted to “Link Attachments”. You can either upload the requested documents or print a coversheet to fax over the documentation.

Review Header Information

Provider #  
Client ID:

Start DX/PROCS VITALS/LABS Clinical Info MEDS SUMMARY ADDL INFO

QUESTION:

ADDITIONAL INFO:  
You can type in a response to the PEND and when you click "Submit Info" you will be prompted to "Link Attachments" you will be able to upload the requested documents or print a coversheet to fax over the requested documents

CANCEL SUBMIT INFO

# Technical Denials for LOI

Prior Authorization Requests (PARs) submitted without required documentation may result in a Technical Denial.

This occurs when:

- PARs are missing appropriate attachments or documentation. The PAR will have record Status of “Awaiting Required Attachments”
- PARs are pended because they require additional information to make a medical necessity determination. The review will be located under the Respond to Add'l info Tab in eQSuite®
- If information is not received within 10 business days from the denial date, the request will be denied due to lack of Information and the requestor must: Submit a reconsideration request and include the required information or Submit a new PAR request with the necessary documentation

# Reconsiderations

The ordering or treating provider may submit a request for a PAR reconsideration of an adverse determination within 10 business days.

PAR reconsideration requests may be submitted electronically (eQSuite®) or by fax.

Click on “Respond to Denial” then click on “Open Review”.

Click on you **DO NOT AGREE**. It is important to enter additional supporting information in the available textbox for our reviewer to use when reevaluating the case.

Once you click on **Submit Recon Info** you will be prompted to attach additional documents to support the Reconsideration request by clicking on the Link Attachment button.

← Create New Review   Respond to Add'l Info   **Respond to Denial**   Online Helpline   Utilities   Reports   Search   Attachment

### Respond to Denial

Cases With Denials   Search By Review ID:

Review_ID	Review Complete Date	Client ID	First Name	Last Name	Initial Service Date	Requestor Name	Setting Type		
1234567	04/01/2020	987654321	Earl	McTesterson Jr.	04/03/2020	T EstUser	DI	<a href="#">Open Review</a>	<a href="#">Link Recon Request</a>

Start   DX CODES/ITEMS   Clinical Info   SUMMARY   ADDL INFO   **RECON**

I agree with eQHealth physician reviewer's adverse determination and waive reconsideration rights

I do not agree with eQHealth physician reviewer's adverse determination and am requesting a reconsideration review

Enter any additional information to be considered with your request for reconsideration that justifies medical necessity of the previously denied or reduced level of services.

Additional supporting documentation will be submitted via upload, or faxed using the barcoded coversheet.

# Peer to Peer Process

The Peer-to-Peer (P2P) process offers the ordering or treating physician an opportunity to discuss a medical necessity denial with an eQHealth physician reviewer prior to initiating a request for reconsideration.

- The ordering/treating physician's office may request a P2P.
- The request must be submitted within five (5) business days from the date of the medical necessity denial.
- Submit the request via the online helpline, by calling customer service, or by fax.

Follow instructions *in the Peer-to-Peer Guide at [www.ColoradoPAR.com](http://www.ColoradoPAR.com)*

# PAR Revisions/Corrections

## Submit a Helpline Ticket

Click on “Online Helpline” in eQSuite® to:

- Cancel a review
- To change a billing provider ID to an affiliated facility
- If you need to shift dates on an authorization

Once you submit your ticket a Ticket # will generate. Once a representative from eQHealth has responded you will receive an email notification and you can log into eQSuite® and view your response. If you have additional questions, please reference the original Ticket# in your new ticket.

Any other changes will need to be made with a new review request as an admission.

The screenshot displays the eQHS Online Helpline interface. At the top, there are navigation tabs: "Create New Review", "Respond to Add'l Info", "Respond to Denial", "Online Helpline" (circled in red), and "Utilities". Below the tabs is the "eQHS Online Helpline" header. A sidebar on the left contains "Menu" and "Errors" options. The main content area is titled "Selected Ticket Info:" and contains instructions: "To enter a new question, type your question in the box below, then click the **Submit Question** link below. You will be e-mailed with a link to return here when this ticket has been processed. To view the response to a previous ticket, scroll down and view the **History** in list below." Below the instructions are input fields for "Review ID:", "PAR #:", "Client #:", and "Admit Date:". A note states: "Do NOT enter other values if Review ID is entered." and "Do NOT enter a Client # or Admit Date if a PAR # is entered." A large yellow text area is provided for the question. A red-bordered box contains a confirmation message: "Your question has been submitted to the helpdesk. Please check back in a short while for a response. If your e-mail address is in the system, you will be notified by e-mail when your question has been addressed." with a "Close" link. At the bottom, a "Q&A History (Last 30 Days)" section is visible, with a "Question/Response" header. A specific entry is shown: "Ticket # 600009 | Receipt Date: 3/10/2020 7:16:14 AM | Response Date:" followed by a "Question:" label and the text "Please type in your request here."

# PAR#s/Letters

Once a final determination has been made, eQHealth transmits the information to Interchange. If the transmit is successful, a PAR# will generate within 24-48 hours.

You will then be able to view or print the letter in eQSuite®.

To view the Letter you will click on the "Letters" Tab click on the "Completed" Tab and you can search by the Client ID of Admit Date.

You can also click on "Reports" and select O3 to view all outpatient assigned PAR numbers.

The screenshot displays two parts of the eQSuite interface. The top part shows the 'Letters Search' section with a navigation bar containing 'Letters' (circled in red), 'Attachments', 'Search', 'Reports', 'Utilities', 'Online Helpline', 'Respond to Denial', 'Respond to Add'l Info', and 'Create New Review'. Below the navigation bar, there are three tabs: 'Completed', 'In Process', and 'Reconsiderations', with 'Completed' selected. A search form includes a dropdown for 'Client ID', a text input field, and a 'Search' button. Below the search form is a table with columns: Admit Date, Last Name, First Name, Client ID, Review ID, PA, and Setting Type. The table is empty, displaying 'No records to display.'

The bottom part of the screenshot shows the 'Provider Reports' section with a navigation bar containing 'Reports' (circled in red), 'Attachments', 'Search', 'Utilities', 'Online Helpline', 'Respond to Denial', 'Respond to Add'l Info', and 'Create New Review'. Below the navigation bar, there is a table titled 'Provider: 99999992 - INPATIENT PROVIDER'. The table has columns for 'Select', 'Code', and 'Description'. The rows are as follows:

Select	Code	Description
Select	A7	Diagnostic Imaging Web Review Request Printout
Select	E7	Multi Service - Web Review Request Printout
Select	I1	Inpatient Review Status for a Given Bene
Select	I2	Inpatient Status of In Process Reviews
Select	I3	Inpatient Assigned PARs
Select	I7	Inpatient Web Review Request Printout
Select	O1	Outpatient Review Status for a Given Bene
Select	O3	Outpatient Assigned PARs
Select	T7	Therapy Web Review Request Printout

# Helpful Resources

- eQSuite Provider Training Documents  
[www.coloradopar.com](http://www.coloradopar.com)
- Department of Health Care Policy & Speech Therapy Billing Manual  
[\(Click Here\)](#)
- Department of Health Care Policy & Financing Provider Fee Schedules  
[\(Click Here\)](#)

# Questions?





# CONTACT US

## *Customer Service*

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[\*co.pr@eqhs.com\*](mailto:co.pr@eqhs.com)

*Or*

*Online Helpline via eQSuite®*

For more information please visit

[\*www.coloradoPAR.com\*](http://www.coloradoPAR.com) - *Provider Resources*

*For HCPF Policy Questions*

[\*HCPF\\_UM@hcpf.state.co.us\*](mailto:HCPF_UM@hcpf.state.co.us)

# Thank You!