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Section 1–Care Management Program Overview

Purpose of Care Management
The purpose of Qualis Health’s Care Management program for the State of Alaska, Department of Health and Social Services (DHSS), Division of Health Care Services (DHCS), is to provide a variety of utilization review and case management services that will help to ensure appropriate medical services are provided to Alaska Medicaid recipients at a reasonable cost and in accordance with state and federal regulations, statutes, and policies. Qualis Health has been providing care management services for Alaska Medicaid for more than 20 years.

Definitions of Utilization Management and Case Management
Qualis Health’s care management programs use the following URAC definitions for utilization management (UM) and case management (CM):

- **Utilization Management**—Evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan; sometimes called “utilization review.”
- **Case Management**—A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a consumer’s health needs through communication and available resources to promote quality cost-effective outcomes.

Both UM and CM work collaboratively to address:

- Appropriate use of health care services
- Efficiency or cost-effectiveness
- Quality of care

Comparison between Utilization Management and Case Management
The table below compares UM and CM services.

<table>
<thead>
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<th>UM Services</th>
<th>CM Services</th>
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<tr>
<td>Reactive (responding to requests for service)</td>
<td>Proactive (identifying optional resources)</td>
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<tr>
<td>Focused on specific treatment/units of service</td>
<td>Broad, holistic approach</td>
</tr>
<tr>
<td>Limited interaction with providers and recipients</td>
<td>Communication with recipients and providers is key</td>
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History of Medicaid Utilization Review and the QIO Program in Alaska

Medicaid, an entitlement program created by the federal government, is the primary program financing basic health and long-term care services for low-income Alaskans. DHCS maintains the Medicaid core services for the State of Alaska. The Alaska Medicaid program provides both mandatory and optional services. Eligibility for Medicaid services is determined by medical necessity and the eligibility category of the recipient.

Inpatient hospital services are included in the mandatory services available under Medicaid. The federal government has expended significant dollars in developing and supporting the utilization review of inpatient hospital care. In fact, this type of review has been required by law for Medicare and state Medicaid programs since 1972.

DHCS has historically contracted with a peer review organization (PRO)—now called a quality improvement organization (QIO)—to review selected inpatient admissions for medical necessity and appropriateness. A QIO is an organization that meets federal requirements for utilization and quality control review and holds a Medicare contract with the Centers for Medicare & Medicaid Services (CMS).

Qualis Health, the CMS Medicare QIO for the states of Washington and Idaho, has been an Alaska Medicaid contractor since 1985, performing utilization reviews and prior authorization services. Reviews are performed on a pre-service, concurrent, or retrospective basis.

Qualis Health’s Background and Experience

Qualis Health is a private, nonprofit health care QIO with 32 years of experience in providing utilization review, case management, and quality improvement services. Qualis Health is based in Seattle, Washington. We also have offices in Anchorage, Alaska; Boise, Idaho; Tustin, California; and Columbia, South Carolina.

Established in 1974, Qualis Health started out as a professional standards review organization (PSRO) for Medicare in the State of Washington. As a PSRO for the first legislated Medicare quality review program, Qualis Health conducted retrospective reviews of hospitalizations to determine whether they were medically necessary. Qualis Health’s Medicare review activities expanded to Alaska in 1984 and to Idaho in 1986.
Qualis Health began offering utilization review services to the Medicaid population in Washington State in 1975. In 1985, Qualis Health was awarded the utilization review contract with Alaska Medicaid. Qualis Health currently serves as a Medicaid contractor in the states of Alaska, Washington, Idaho, and South Carolina.

Qualis Health started offering utilization review services to private industry in 1979. We have been a presence in the private-sector market in Alaska since 1984, when we added our first care management client.

Today, Qualis Health continues to serve all three sectors—Medicare, Medicaid, and private industry. Because Qualis Health is a third party that is not affiliated with any provider organizations nor with the insurance industry, we are able to objectively evaluate the medical necessity and quality of health care provided to the clients that we serve.

As the Medicare QIO for the states of Washington and Idaho, Qualis Health protects the integrity of the Medicare Trust Fund by reviewing services to ensure they are medically necessary. We also improve the quality of care for Medicare beneficiaries by helping to ensure that their care meets professionally recognized standards for health care.

For our Medicaid and private-sector customers, we offer a range of programs designed to control health care costs while improving the quality of health care delivered to consumers. These programs include traditional utilization management services such as pre-service, concurrent, retrospective chart, and retrospective telephonic reviews; coding validation; and medical consultation.

In the late 1980s, Qualis Health launched nurse case management services for Medicaid and the private-sector. Our Medicaid case managers work with patients who have catastrophic illnesses and injuries. They also work with these patients’ families, providers, physicians, and Alaska Medicaid to promote the right care at the right time and in the right setting. Qualis Health’s case management program is nationally recognized for excellence and superior results.

Qualis Health’s offices in Seattle and Anchorage have full accreditation from URAC for their Health Utilization Management and Case Management programs, demonstrating compliance with the highest industry standards for pre-service, concurrent, retrospective reviews, and case management services. The URAC accreditation for Health Utilization Management assures providers, physicians, and patients that the review processes we follow are fair and impartial, and that URAC standards for review time frames, reviewer qualifications, appeal procedures, and confidentiality of information are met, thus resulting in high quality services and objective review decisions.
Qualis Health’s Professional Expertise

More than 200 Qualis Health professionals, including department leaders, medical directors, clinical reviewers, case managers, quality improvement specialists, biostatisticians, communications specialists, information technology specialists, and administrative support staff, work hard to serve the needs of our various clients. In addition, Qualis Health has an extensive network of more than 300 physician/practitioner consultants (P/PCs) who serve as consultants to the organization and provide collaborative clinical peer review services. The network includes physicians representing all 24 of the specialty boards recognized by the American Board of Medical Specialties as well as dentists, chiropractors, naturopaths, and other complementary and alternative medicine practitioners.

Qualis Health’s employees have well-established relationships with facilities and health plans, allowing for effective collaboration in health care evaluation and improvement. As part of a continuing effort to work in cooperation with the community, Qualis Health is actively pursuing new provider and physician partnerships.

Qualis Health’s Mission and Vision

The mission of Qualis Health is to generate, apply and disseminate knowledge to improve the quality of health care delivery and health outcomes. Qualis Health’s vision is to be recognized for leadership, innovation and excellence in improving the health of individuals and populations.
Section 2–Communications with Qualis Health

Introduction

Qualis Health’s review process is flexible and is set up to handle review requests received via telephone, fax, mail, or submitted over the Internet. We maintain toll-free, dedicated phone and fax numbers for Medicaid providers to use to request review services. We also offer Web-based reviews using iEXCHANGE®—MEDecision’s browser-based product that uses the Internet to create a two-way link that can be used to exchange care management data, thus facilitating real-time, online approvals.

Our regular business hours are 5:30 a.m. to 5:00 p.m. Alaska Time, Monday through Friday, excluding standard State observed holidays. Qualis Health staff members are available to handle review requests received during regular business hours.

Contacting Qualis Health by Phone

Qualis Health depends upon our telecommunications systems to make our UM review programs work effectively. Qualis Health has installed an advanced, state-of-the-art telecommunications system that includes a confidential voice mail system and an Automatic Call Distribution (ACD) group in the telephonic review area. This ACD group routes incoming calls to our intake representatives and clinical reviewers. In addition, a telephone monitoring system has been installed to allow Qualis Health’s directors and managers to supervise the responsiveness and performance of the intake representatives and clinical reviewers.

To reach Qualis Health’s Telephonic Review Services, call 800-783-9207 and then press 1. Qualis Health’s voice mail system is available 24 hours a day. After business hours and in the event that no one is immediately available to answer your call, you will reach the voice mail system. The amount of time that you will have to wait for the voice mail system when an intake representative or clinical reviewer is not available will not exceed 35 seconds due to a programmed element in the system.

When you do not reach an intake representative or clinical reviewer directly, you can leave a detailed confidential voice message. During regular business hours, we monitor the voice mail system at least hourly to triage messages and to direct clinical reviewers so that callbacks are handled appropriately and efficiently. Messages left after hours are retrieved first thing on the next business day, with calls returned by 12:00 p.m. PST and 11:00 a.m. Alaska time.
When accessing the voice mail system to leave a message, please follow the directions given by the mail attendant system. You will be asked to supply the information as listed in Section 9, Process and Procedures for Urgent Inpatient Admissions and Outpatient Procedures.

**Contacting Qualis Health by Fax**

Provider may fax review requests to Qualis Health at 800-826-3630. The fax must be legible and include all the necessary demographic and clinical information that is required to complete the review. Exhibit 8 contains a sample FAX review form that can be used. You can; however, use your own fax form as long as the information is complete. A fax cover sheet with a confidentiality disclaimer is highly recommended.

**Qualis Health’s toll-free fax number for review requests is:**

(800) 826-3630

**Contacting Qualis Health by Mail**

Pre-service and concurrent review requests may also be mailed to Qualis Health’s Seattle office. The address is:

Qualis Health
PO Box 33400
Seattle, WA 98133-0400

**Contacting Qualis Health via Internet**

Providers that wish to submit Web-based review requests, will need to obtain a User ID, iEXCHANGE ID, and password to login and access iEXCHANGE. Providers who have been trained to use iEXCHANGE and have their own IDs and password, can login to iEXCHANGE and directly enter information for the pre-service or concurrent review request. For information about or to learn how to submit Web-based review submissions, please go to Qualis Health’s Web site (www.qualishealth.org) or contact one of the following individuals:

- Flipper Harris, RN, CCM, Provider Relations Coordinator—Ms. Harris can be reached by phone at 800-949-7536 ext. 2762, or by e-mail at flipperh@qualishealth.org
- Linda Peake, RN, CPUM, IQCI, Manager, Utilization Management—Ms. Peake can be reached by phone at 800-949-7536, ext. 2276, or by e-mail at lindap@qualishealth.org
Qualis Health’s Communication of Review Determinations

Our Web-based solution, iEXCHANGE, offers immediate feedback from Qualis Health concerning the request for review—approved, pended for further review, or additional information required. For requests submitted through iEXCHANGE, an Internet-based notification of the final determination and certification number is posted to iEXCHANGE for the provider. Providers will not need to wait for a phone call or for the transmission of a fax document to learn of the final determination.

For requests that are not submitted through iEXCHANGE, Qualis Health will communicate the determination and the certification number to the provider via phone or fax. We will not send letter notifications on certified reviews. We will send letter notifications for all non-certified reviews and appeal reviews. These notifications will be sent to the Department, recipient, attending physician, and facility within one business day of the date the decision is made.
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Section 3–Compliance with URAC’s Utilization Review Standards

Frequently Asked Questions about Utilization Review Decisions

Qualis Health complies with URAC health utilization management (UM) standards when performing utilization reviews. These standards provide a process for conducting a utilization review that is clinically sound and respects recipients’ and providers’ rights. URAC standards ensure that only appropriately trained, qualified clinical personnel conduct and oversee the utilization review process; that a reasonable and timely appeals process is in place; and that medical decisions are based on valid clinical criteria. Some frequently asked questions about the process of making utilization review decisions are answered next.

1. *Who makes the utilization review decision?*

   URAC Health UM Accreditation requires Qualis Health to use a three-step process to determine if a proposed medical treatment or service is medically necessary:

   - **Initial Clinical Review**—A licensed health professional, such as a registered nurse, licensed practical nurse, occupational therapist, physical therapist, or social worker conducts this first, critical step of the review process using InterQual® medical necessity criteria. If the clinical information provided does not meet InterQual criteria, or if, in the clinical reviewer’s judgment, a physician should review the case, it is referred for peer clinical review.

   - **Peer Clinical Review**—A licensed physician qualified to render a clinical opinion about the proposed treatment or service performs a peer clinical review by reviewing all available information and then making a decision on whether care should be certified or not. When a non-certification decision is made, the attending physician has the opportunity to discuss the review and proposed care with a Qualis Health physician, prior to final determination (also see Questions #2 and 3 below). If the result of that conversation is not satisfactory for the attending physician, an appeal process is available.

   - **Appeal Process**—The recipient or the provider may initiate the appeal. The appeal review is performed by a qualified, board-certified physician within the same specialty but not involved in the initial review decision. The process must be expedited, if requested.

2. *Why is a peer-to-peer conversation important?*

   The goal of the peer-to-peer conversation is to allow the treating provider a chance to discuss a UM determination before the initiation of an appeal process. It
is hoped that some disagreements can be resolved without the need for a formal appeal process.

3. **What are the timeframes for peer-to-peer conversation?**

Qualis Health offers peer-to-peer conversation availability, with time constraints, for potential non-certifications. A Qualis Health representative will notify the facility utilization review coordinator of the potential non-certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer-to-peer discussion. At the same time, Qualis Health’s physician reviewer will, in most cases, independently attempt to contact the attending physician.

If a peer-to-peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 5:00 p.m. Alaska Time (6:00 p.m. Pacific Time) the day following notification of the potential non-certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 5:00 p.m. Alaska Time (6 p.m. Pacific Time) the next business day.

If the case is non-certified after the peer-to-peer conversation, the stay will be non-certified retroactively to the day medical necessity was not met. If the attending physician does not call by 5:00 p.m. Alaska Time (6 p.m. Pacific Time) of the following day, the case will be non-certified. The attending physician may use the physician "hotline" number, which is 1-877-292-2615, to discuss the recipient's case.

4. **What recourse is there when we disagree with a determination?**

Qualis Health’s written notice of non-certification decision contains instructions of initiating an appeal of the non-certification. Please see Section 15 of this manual for details on the appeal process. If, after an appeal, you still disagree with the Qualis Health determination, your appeal letter will outline the steps that must be taken to request a hearing with the Alaska Division of Health Care Services. Section 15 has more information about this process as well.

5. **What is considered an urgent review?**

An urgent review is performed when a case involves urgent care. A case is considered to involve urgent care whenever the application of the time periods for making non–urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient’s medical
condition, would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

6. **How are review timelines determined?**

The number of days allotted for each type of review is based on URAC Health Utilization Management Standards. It is different for urgent review than it is for non-urgent review. If the review requires that additional information be gathered, clinical peer review to take place, or a peer-to-peer conversation occur, additional time is allotted. Review timelines are also addressed in Questions #7 and 8 below.

7. **What are the timeframe for completion of urgent reviews?**

With all necessary clinical information has been received and no referral for clinical peer review is needed, the timeframes for completion of urgent reviews are as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Concurrent Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
</tbody>
</table>

When additional information is required to complete the review, the timeline is adjusted accordingly.

8. **What are the timeframes for completion of non-urgent review?**

When all necessary clinical information has been received and no referral for clinical peer review is needed, the timeframes for completion of reviews are as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service Review—Non-Urgent</td>
<td>Fifteen (15) calendar days</td>
</tr>
<tr>
<td>Concurrent Review—Non-Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

When additional information is required to complete the review, the timeline is adjusted accordingly. Qualis Health may choose to exercise a single extension of up to 15 calendar days on non-urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial
decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision.

9. What is the three-day benchmark?
All stays that do not require a pre-admission review must be reviewed if the hospital stay is expected to exceed three days. This will be a concurrent review and it is referred to as the three-day benchmark. With the three-day benchmark, a review must be obtained if patient is not discharged by the third day (day of admission is day one). The review must occur on or before day four of stay.

10. What is the exception to the three-day benchmark?
The length of maternal and newborn stay related to childbirth is the exception to the three-day benchmark. According to State of Alaska Regulation 7 AAC 140.320, the length of maternal and newborn stay related to childbirth is:

- For Vaginal delivery—48 hours from delivery (Delivery/birth is the day after admission, and discharge is within two days of delivery)
- For Cesarean delivery—96 hours from delivery (Delivery/birth is the day after admission, and discharge is within four days of delivery)
Section 4–HIPAA

Business Associate Standing
Qualis Health provides care management services on behalf of its clients and is considered a “Business Associate” of these clients under the Health Insurance Portability and Accountability Act (HIPAA) “Administrative Simplification” regulations governing patient health information. These regulations include the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule") and the Security Standard ("Security Rule").

DHCS Letter to Alaska Medicaid Providers
On April 18, 2003, the Division of Health Care Services (DHCS) sent a letter to Alaska Medicaid providers regarding its position on HIPAA. The text of that letter is presented on the next page.
Date: April 18, 2003

To: Alaska Medicaid Provider

From: State of Alaska Department of Health and Social Services
Division of Health Care Services and Qualis Health

Re: Health Insurance Portability and Accountability Act (HIPAA) Uses and Disclosures of Protected Health Information General rules of 45 CFR 164.502(a)(1)(ii), (iii) and 45 CFR 164.502(e)(i); and Uses or Disclosures to Carry out Treatment, Payment, or Health Care Operations 45 CFR 164.506.

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Department of Health and Social Services (DHSS) is considered a covered entity. As a covered entity, all of the Divisions within DHSS, such as the Division of Health Care Services (DHCS), may contract with organizations to support the Divisions in the performance of their duties. These organizations are referred to under the HIPAA Privacy rules as business associates.

Qualis Health is considered a Business Associate for Alaska Division of Health Care Services.

As a Business Associate, Qualis Health is permitted to receive Protected Health Information (PHI) in order to conduct their contracted work. Also, as a Business Associate of DMA, Qualis Health is allowed under HIPAA to obtain PHI related to Medicaid or Chronic and Acute Medical Assistance (CAMA) patients from providers and others without obtaining written authorization from the patient. This is allowed when Qualis Health is conducting functions that are related to treatment, payment, or health care operations (TPO).

Qualis Health’s goal is to continue to conduct operational activities for the Alaska Division of Health Care Services program while complying with the applicable HIPAA regulations.

Incidental disclosures of protected health information are permitted by the HIPAA privacy rule under 45 CFR 502 (a) (iii). In the case of an incidental disclosure, covered entities are required to comply with the minimum necessary standards of the privacy rule with respect to a disclosure that is otherwise permitted or required.

If there are any questions regarding this issue, please contact one of the following representatives for further clarification:

- Susan Dunkin, Alaska Division of Health Care Services, at 907-269-3638
- Deon Westmorland, Qualis Health, at 206-368-7230
Section 5–Provider Billing Concerns

Claim Discrepancies

Providers are encouraged to thoroughly examine discrepancies in claims for accuracy prior to contacting Qualis Health. The fiscal agent for the Alaska Division of Health Care Services has a provider inquiry telephone line for this purpose. The numbers to call are as follows:

- Anchorage providers should call 907-561-5650
- In-state providers outside of Anchorage should call 1-800-770-5650
- Out-of-state providers should call 907-561-5650 (there is no toll-free number)

Providers may call Qualis Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. Some examples of such discrepancies are as follows:

- The date(s) on the Qualis Health review does not match the certified admission or discharge date on the claim
- Admitting or principal diagnosis and/or all procedure code(s) on the Qualis Health review do not match the code(s) on the claim
- Incorrect recipient Medicaid Identification number indicated on the Qualis Health review
- Case ID number used for billing does not match the case ID number on the Qualis Health review (Note: Case ID number must be noted on the claim)

Certification Modifications

Sometimes information changes between the time the certification is completed and the time of billing. If changes are necessary, please complete Exhibit 16, the Certification Modification Request Form. The completed form should then be faxed to Qualis Health at 1-800-826-3630.

Personnel at Qualis Health will make the requested changes and forward the information to the fiscal agent. You will receive confirmation that the changes have been made by fax.

Note: A change of diagnosis, procedure, dates of service or eligibility may result in the necessity of further review. You will be notified if additional review is required.
Contingency for Payment

Qualis Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.
Section 6–Eligibility Categories

Overview
There are times when Alaska Medicaid recipients could be covered under another insurance or program, and the requirements for review may vary. The following examples will assist you in determining which review requirements will apply.

Dual Eligibility Examples
The following tables illustrate how dual eligibility impacts the requirement for medical review.

Example 1

<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Coverage is Medicare Part A and</td>
<td>No Medicaid Review is Required</td>
</tr>
<tr>
<td>Secondary Coverage is Medicaid</td>
<td>(Unless inpatient Medicare benefits have been exhausted or services</td>
</tr>
<tr>
<td></td>
<td>are not covered by Medicare, in which case Qualis Health should</td>
</tr>
<tr>
<td></td>
<td>proceed with a review for Medicaid)</td>
</tr>
</tbody>
</table>

Example 2

<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Coverage is Medicare Part B and</td>
<td>Medicaid Review is Required</td>
</tr>
<tr>
<td>Secondary Coverage is Medicaid</td>
<td></td>
</tr>
</tbody>
</table>

Example 3

<table>
<thead>
<tr>
<th>If:</th>
<th>Then:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Coverage is Other Insurance (e.g., Blue Cross, Aetna, etc.) and Secondary Coverage is Medicaid</td>
<td>Medicaid Review is Required</td>
</tr>
</tbody>
</table>
This page is intentionally blank.
Section 7–Utilization Review Process Overview

Submission Modes
Qualis Health will accept review requests submitted by providers over the Internet, or received via telephone, fax, or mail.

<table>
<thead>
<tr>
<th>Submission Mode</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internet</td>
<td>Providers log in to iEXCHANGE and directly enter information for the pre-service, concurrent or retrospective review request.</td>
</tr>
<tr>
<td>Fax</td>
<td>Providers may request pre-service, concurrent or retrospective reviews by faxing the request to our toll free fax number: 800-826-3630.</td>
</tr>
<tr>
<td>Phone</td>
<td>Providers may request pre-service, concurrent or retrospective reviews by calling our toll-free number: 800-783-9207. Providers who call after hours or on holidays and week-ends will be prompted to leave a message or call back on the next business day.</td>
</tr>
<tr>
<td>Mail</td>
<td>Requests can be mailed to Qualis Health’s Seattle office: Qualis Health PO Box 33400 Seattle, WA 98133-0400</td>
</tr>
</tbody>
</table>

Eligibility Verification
Qualis Health does not verify recipient eligibility for pre-service review. The following information is available to assist the provider in the eligibility verification process.

ID Cards and Coupons—The Department of Health and Social Services (DHSS), Division of Public Assistance (DPA), produces and distributes medical assistance identification cards and medical coupons. These verify that a recipient is eligible to receive services from the Alaska Division of Health Care Services in a given month. Cards and coupons contain the eligible recipient’s name, identification number, date of birth, eligibility month and year and eligibility code. Please note that the Resource Code on the coupon or ID card will indicate if the recipient has a payment source in addition to medical assistance. Refer to your “Billing Manual” from the fiscal agent for further clarification.
Eligibility Verification System (EVS)—The fiscal agent provides and maintains the Eligibility Verification System (EVS) to help providers determine the eligibility of the recipients. Each enrolled provider receives a unique EVS PIN number and instructions for using EVS. A provider with a touch-tone telephone can use the EVS identification number to verify recipient eligibility 24 hours a day, seven days a week. The EVS may be accessed by calling 1-800-884-3223.

Providers may receive eligibility verification by contacting the fiscal agent at 1-800-770-5650 (toll-free in Alaska) or 907-644-6800.

First-level Non-Physician Review Using InterQual Criteria Modules

Qualis Health provides all utilization review services in accordance with URAC health UM standards. URAC recognizes two levels of review—clinical review (first-level review) and peer clinical review (second-level review). The first-level review process begins when the facility, provider, or patient contacts Qualis Health to request a review.

When the request is received via iEXCHANGE, phone, fax, or mail, basic demographic information is collected and the case is entered into our medical management system. A clinical reviewer is assigned to perform the review using McKesson’s InterQual® medical necessity criteria and, as applicable, contract-specific criteria. InterQual criteria are based on well-researched medical evidence that is reviewed and updated annually by McKesson. Qualis Health currently uses the following InterQual criteria sets for non-physician utilization review:

- Acute (Adult and Pediatric)
- Behavioral Health
- Rehabilitation (Inpatient, Outpatient, and Chiropractic)
- Surgical Procedures (Adult and Pediatric)
- Home Care
- Sub-acute Care
- Skilled Nursing Care
- Long-term Acute Care
- Durable Medical Equipment
- Imaging
If medical necessity and appropriateness of the level of care can be established through the application of InterQual criteria, the clinical reviewer approves the treatment or the admission for an appropriate number of days and provides notification of the certification. When the requested services involve inpatient treatment, the clinical reviewer uses the current edition of Solucient’s Length of Stay (LOS) by Diagnosis and Operation to identify an appropriate LOS and set a “next review” point for concurrent review. Qualis Health will notify the requester of the certification (approval). If appropriate level of care and/or medical necessity criteria is not met, secondary medical review is required and the case is referred to a Qualis Health medical director or a physician/practitioner consultant (P/PC) for a peer clinical review.

Second-level Peer Review

Upon receipt of the case, the Qualis Health physician reviewer (e.g., medical director or P/PC) will review the information that has been received and use his/her specialty expertise and clinical judgment in making the second-level review determination. The physician advisor will also have up-to-date reference materials and guidelines available to help ensure that the review determination is based on current evidence-based best practice guidelines in conjunction with accepted standards of practice.

In the event of a potential non-certification determination, Qualis Health will contact the attending provider and give the provider the opportunity to discuss the review with our physician reviewer. If the attending provider wants a peer-to-peer conversation it must be timely and, to comply with URAC timeframes, must occur within one business day of the offer for the conversation. If the peer-to-peer conversation does not occur within this time frame, the non-certification determination is issued. If the peer-to-peer conversation occurs, Qualis Health will issue a determination following the discussion.

Qualis Health will notify the provider by phone, FAX or iEXCHANGE®, of the determination. If the determination involves non-certification, we will also generate written notification of the decision within one business day of the date the decision is made. The non-certification notification will include appeal rights.
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Section 8–Web-based Utilization Review Submissions

Purpose
Qualis Health has adopted iEXCHANGE®, a browser-based product from MEDecision that uses the Internet to create a two-way link between health care providers and payers to facilitate the utilization management review process. iEXCHANGE allows physicians, facilities, and other health care providers to submit utilization review requests to Qualis Health using a secure Internet connection.

Responsibility
Providers that elect to use iEXCHANGE are responsible for entering the review request in iEXCHANGE using InterQual criteria.

Requirements
Use of iEXCHANGE requires Internet access, completion of iEXCHANGE training, registration of users, and establishment of provider logon information. iEXCHANGE training is conducted by the Qualis Health provider relations coordinator via WebEx sessions. If you are interested in receiving iEXCHANGE training please see Qualis Health’s website at:


Or, contact Flipper Harris, RN, CCM, Qualis Health’s provider relations coordinator. Ms. Harris can be reached by phone at: 800-949-7536, ext. 2762, or by e-mail at: flipperh@qualishealth.org

Process and Procedures
Submission—If you have already received iEXCHANGE® training from Qualis Health, submit your review requests via the Internet at the following Web address:

https://iEXCHANGE.medecision.com/IEApp/Logon.jsp?MCOBranding=QUA1

Required Review Documentation—The following basic information is needed for each review/request:

- Recipient name
- Recipient birth date
- Complete recipient address
- Recipient telephone number
- Sex of recipient
- Recipient Medicaid ID number
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Section 8 – Web-based Utilization Review Submissions

- Admitting diagnosis and ICD–9–CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD–9–CM code(s)
- Procedure(s) to be performed, including the ICD–9–CM code(s) and/or CPT code(s)
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admit date and/or surgery date

Medical Necessity Screening—Once the information for the review has been received, the Qualis Health clinical reviewer will assess the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements for the level of care and the type and number of services requested. If the InterQual Severity of Illness and Intensity of Service screening criteria are met, the Qualis Health clinical reviewer will issue a Case ID number and the review will be certified. A length of stay will be determined and we will establish the date when a concurrent review will be conducted if the recipient has not been discharged. Refer to Exhibit 1, Pre-service Review Flow Chart.

Qualis Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review—Cases that do not meet criteria are referred for clinical peer review by a Qualis Health physician reviewer (medical director or P/PC). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. If a peer-to-peer conversation is requested, our physician reviewer and the recipient’s attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion,
Qualis Health will either certify or non-certify the admission. See Section 3, Questions #2 and 3 for more information about the peer-to-peer conversation, including the time constraints involved in holding the conversation.

Non-certifications—If the Qualis Health physician reviewer non-certifies the admission, a Qualis Health representative will notify the appropriate provider (e.g., attending physician, facility) by telephone. We will also send non-certification letters within one working day to the following parties: the recipient, attending physician, facility, and the Department.

The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health’s initial non-certification determination. Refer to Section 15 of this manual for a detailed description of the appeal procedure.

The Department will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a consequence of an appeal review by Qualis Health or a provider appeal or recipient fair hearing by the State.

Questionnaires—In the near future, we expect there will be questionnaires and checklists within the iEXCHANGE system associated with specific procedures and/or diagnosis. These questionnaires/checklists will appear within the request/review for completion. The questionnaire/checklist will eliminate the need to add information to the Clinical Findings area by using check boxes and short text.

The iEXCHANGE Training Manual may be accessed using the following link: http://www.qualishealth.org/sites/default/files/AKMedicaid_iEXCHANGEManual_DHCS.pdf

Submitting Retrospective (Retro) <15 Day Reviews—Providers MAY submit retro <15 day reviews for medical/surgical reviews via iEXCHANGE. There is no need to submit the UB-04 form, a history and physical, or a discharge summary. You should include sufficient information for the clinical reviewer to complete the review. No day-by-day account is required. Document the following information in the Communication field:

- Retro <15 day review
- Admit and D/C date
- Previous Case ID# (if applicable)
- Contact Name and Phone Number
- It is necessary to include that you verified Medicaid eligibility
Providers MAY NOT submit the following Retro reviews via iEXCHANGE:

- Lengths of stay 15 days or greater; these continue to require submission of the entire medical record
- Reviews with a length of stay start date more than 365 days in the past are ineligible to be submitted via iEXCHANGE; an error message will display

**Timeframes**

The timeframes for completion of iEXCHANGE reviews are as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Pre-service Review—Non-Urgent</td>
<td>Fifteen (15) calendar days</td>
</tr>
<tr>
<td>Concurrent Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Concurrent Review—Non-Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>
Section 9–Pre-Service Utilization Reviews

Purpose
Care management best practice has found that the most effective form of review takes place before the recipient enters the facility. The chief advantage is that medically unnecessary admissions can be avoided.

The Alaska Division of Health Care Services (Department) has determined that certain select diagnoses and frequently performed procedures will require pre–service review. This list of medical conditions and procedures is contained in Appendix A.

The Department has varying review requirements for pre-service review. Surgical necessity review is required for select inpatient and outpatient non-urgent surgical procedures and medical necessity review for select medical conditions to assure that inpatient hospitalization is warranted.

Responsibility
The recipient’s attending physician is ultimately responsible for obtaining the pre-service review from Qualis Health. The attending physician is most knowledgeable about the recipient’s medical history and condition, however, Qualis Health will accept calls for pre-service review from the surgeon when applicable, physician office personnel, or facility personnel (i.e., utilization review coordinator, admitting office, patient accounts office). The clinical reviewer is to receive all of the appropriate clinical information to satisfy InterQual criteria before the pre-service review will be certified.

Requirements
Pre–service review is required for all inpatient admissions and outpatient procedures included on the Select Diagnoses and Procedures List (Appendix A). However, a review is required only if the admitting/principal diagnosis or procedure (inpatient and outpatient) is on the select list and the facility is approved for Medicaid coverage by the Department.

Qualis Health will request a minimum notice of one week prior to all non-urgent inpatient hospitalizations or outpatient appointments for those diagnoses or procedures included on the select pre–authorization list. Requests for pre-service review may be made up to four weeks prior to the scheduled admission or procedure.

Non-urgent pre-service review approvals are valid for four (4) months with the exception of all transplant approvals, which are valid for six (6) months from the date of initial authorization.
Qualis Health may request updated clinical information from providers prior to their performing the procedure. If an admission or procedure date changes, the provider must notify Qualis Health prior to the scheduled admission.

**Process and Procedures for Diagnoses and Procedures on Select Pre-authorization List**

Operational hours for Alaska Medicaid review are:

5:30 a.m. to 4:45 p.m. Alaska Time (6:30 a.m. to 5:45 p.m. Pacific Time),
Monday through Friday

The physician or designated personnel may submit the pre-service review request to Qualis Health via iEXCHANGE (preferred method), or by phone, fax, or mail.

<table>
<thead>
<tr>
<th>How to Reach Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>iEXCHANGE</td>
</tr>
<tr>
<td>Phone</td>
</tr>
<tr>
<td>Fax</td>
</tr>
</tbody>
</table>
| Mail | Qualis Health  
PO Box 33400  
Seattle, WA 98133-0400 |

Calls to the above listed phone number will come into Qualis Health’s Medicaid intake representatives and clinical reviewers. In the event that no one is immediately available, callers have the option of waiting on the line for the next available person or leaving a message in the voice mail system. Instructions are clearly stated for accessing the electronic voice mailboxes which are monitored at least hourly so that clinical reviewers can prioritize those messages and return calls in a timely and efficient manner. Refer to Exhibit 8 for the Pre–service Review Request FAX Form.

**Information Needed for the Review**—Qualis Health intake representatives will collect the following basic information for those reviews requiring pre-service review:

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD–9–CM code
Medical Necessity Screening—Once the information for the review has been received, the Qualis Health clinical reviewer will assess the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements for the level of care and the type and number of services requested. If the InterQual Severity of Illness and Intensity of Service screening criteria are met, the Qualis Health clinical reviewer will issue a Case ID number and the review will be certified. A length of stay will be determined and we will establish the date when a concurrent review will be conducted if the recipient has not been discharged. Refer to Exhibit 1, Pre-service Review Flow Chart.

Qualis Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

Second-level Peer Review—Cases that do not meet criteria are referred for clinical peer review by a Qualis Health physician reviewer (medical director or P/PC). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. If a peer-to-peer conversation is requested, our physician reviewer and the recipient’s attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion, Qualis Health will either certify or non-certify the admission. See Section 3,
Questions #2 and 3 for more information about the peer-to-peer conversation, including the time constraints involved in holding the conversation.

Non-certifications—If the Qualis Health physician reviewer non-certifies the admission, a Qualis Health representative will notify the appropriate provider (e.g., attending physician, facility) by telephone. We will also send non-certification letters within one working day to the following parties: the recipient, attending physician, facility, and the Department.

The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health’s initial non-certification determination. Refer to Section 15 of this manual for a detailed description of the appeal procedure.

The Department will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a consequence of an appeal review by Qualis Health or a provider appeal or recipient fair hearing by the State.

Process and Procedures for Urgent Inpatient Admissions and Outpatient Procedures

When an urgent admission or procedure which is on the pre-authorization list occurs either during normal business hours or on a weekend or legal holiday, providers or designated facility personnel are required to notify Qualis Health within one working day. This can be accomplished by calling the toll-free number during normal business hours. A non-physician reviewer who will conduct the review will answer the call, or a detailed message can be left on the electronic voice mail system. A recorded message instructs the caller on how to access the voice mail system. In order for Qualis Health to prioritize callbacks appropriately, the pertinent information must be given when leaving a message. This includes:

- Your name
- Your telephone number, including area code, beeper number or extension
- Physician full name
- Recipient name (with the correct spelling)
- Recipient ID number (Medicaid)
- Recipient date of birth
- Facility name
- Date and time of admission or surgery
- Diagnosis or surgical procedure
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Section 9 – Pre-Service Utilization Reviews

- ICD-9 diagnosis codes and ICD-9 or CPT procedure codes
- Case ID number for continued stay review

Leaving the aforementioned information in the electronic voice mail system does not complete the review process or automatically certify the review. It will be Qualis Health’s responsibility to return your call and initiate the review process. The same review guidelines and notification process for certifications and non-certifications as was previously described will be followed.

The care and treatment of the recipient never should be delayed, particularly in urgent situations, in order to obtain Qualis Health certification.

Medical Transfer Reviews
Medical transfer reviews are required for inter-facility transfers. An inter-facility transfer is a transfer from one inpatient facility to another inpatient facility. The receiving (“transferred to”) facility will need to initiate a new review for the medical transfer. Thus, each facility will have a unique Case ID number to use on their UB-04 claim form. The following special considerations apply:

- If the recipient is not admitted to the transferring facility as an inpatient, the receiving facility does not need to obtain precertification, as this is not considered a transfer for review purposes
- All transfers from one acute inpatient setting to another require a precertification review. They will be evaluated to ensure that the patient continues to meet severity of illness and intensity of service criteria.
- A transfer from a non-acute bed (i.e., swing bed or skilled nursing facility) is not considered a transfer for review purposes and is treated as a new admission.

Also see Section 11, Physical Rehabilitation Reviews for information about physical rehabilitation transfer reviews.

Timeframes
The timeframes for completion of reviews are as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-service Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Pre-service Review—Non-Urgent</td>
<td>Fifteen (15) calendar days</td>
</tr>
</tbody>
</table>
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Section 10–Concurrent Utilization Reviews

Purpose

Concurrent review takes place during the time in which a recipient is confined to the facility. The purpose is to determine if the facility confinement and associated physician services are medically necessary and appropriate. Qualis Health will perform concurrent reviews for recipients when one of the following situations occurs:

- Concurrent review will be done when the recipient’s facility confinement reaches the review date assigned by Qualis Health at the time of the pre-service review (“scheduled discharge date”) and when discharge on that day is unlikely.
- For those diagnoses and procedures not included on the select preauthorization list, there is a three-day benchmark that applies. These cases will be reviewed concurrently when the recipient’s facility confinement reaches day four. On day four, the admission is reviewed from the admission date. Concurrent reviews will be done thereafter at intervals determined by Qualis Health.

Responsibility

The facility will be responsible for securing concurrent review back to the day of admission from Qualis Health when a recipient’s facility confinement reaches day four or the assigned review date.

Requirements

If the recipient is admitted with a diagnosis which does not require pre-service review and the diagnosis subsequently changes to one of the select diagnoses listed in Appendix A, providers will be required to call Qualis Health within one working day to obtain certification if a review has not been initiated. If a concurrent review is in progress and a recipient requires surgery for one of the selected procedures on the pre-authorization list, providers are required to call Qualis Health to obtain certification within one working day.

If a review has not been initiated with Qualis Health and the decision is made to perform a surgery on the pre-authorization list, post-admission, the provider must call Qualis Health prior to the procedure if it is non-urgent or within one working day if the surgery is urgent.

Once a review has been initiated with Qualis Health, the review process will continue until one of the following occurs:
The recipient is discharged
- The recipient is transferred to another facility
- Concurrent review is non-certified by Qualis Health
- The recipient loses Medicaid eligibility
- The recipient becomes eligible for Medicare Part A after admission

**Process and Procedures**

Operational hours for Alaska Medicaid review are:

5:30 a.m. to 4:45 p.m. Alaska Time (6:30 a.m. to 5:45 p.m. Pacific Time),
Monday through Friday

The physician or designated personnel may submit the concurrent review request to Qualis Health via iEXCHANGE (preferred method), or by phone, fax, or mail.

See **Exhibit 11**, Concurrent Review Request Form.

<table>
<thead>
<tr>
<th>How to Reach Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>iEXCHANGE</strong></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>
| **Mail** | Qualis Health  
PO Box 33400  
Seattle, WA 98133-0400 |

Qualis Health does not verify Alaska Medicaid eligibility for those reviews requiring concurrent review. It is the responsibility of the provider to verify eligibility prior to the review request.

**Information Needed for the Review**—Qualis Health intake representatives will collect the following basic information for the review:

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD–9–CM code
- Physician name
- Physician address
### Medical Necessity Screening

Once the information for the review has been received, the Qualis Health clinical reviewer will review the medical information to assess the recipient’s progress for the days being evaluated. InterQual criteria will be applied to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements. If InterQual criteria are met, the Qualis Health clinical reviewer will issue a Case ID number (if not previously obtained in a pre-service review) and the concurrent review will be certified. An approved length of stay will be determined and we will establish the next assigned review date if the recipient has not been discharged. Refer to **Exhibit 2**, Concurrent Review Flow Chart.

Qualis Health certification indicates only that the admission, procedure, or continued hospitalization is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

### Second-level Peer Review

Cases that do not meet criteria are referred for clinical peer review by a Qualis Health physician reviewer (medical director or P/PC). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. If a peer-to-peer conversation is requested, our physician reviewer and the recipient’s attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion,
Qualis Health will either certify or non-certify the admission. See Section 3, Questions #2 and 3 for more information about the peer-to-peer conversation, including the time constraints involved in holding the conversation.

**Non-certifications**—If the Qualis Health physician reviewer non-certifies all or part of the stay, a Qualis Health representative will notify the appropriate provider (e.g., attending physician, facility) of the adverse determination by telephone. We will also send non-certification letters within one working day to the following parties: the recipient, attending physician, facility, and the Department.

The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health’s non-certification determination. Refer to Section 15 of this manual for a detailed description of the appeal procedure.

The Department will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a consequence of an appeal review by Qualis Health or a provider appeal or recipient fair hearing by the State.

**Procedures for Concurrent Reviews Due on Weekends and Holidays**

In those instances where the concurrent review date falls on a weekend or holiday, the following procedure is to be followed:

- If the concurrent review is due on Saturday, Sunday or a holiday, the concurrent review will take place on the following Qualis Health business day. Non-certification can be retrospective to the first day the recipient was not meeting acute level of care.

**Alternatives to Discharge**

**Administrative Wait Days, Swing Bed Review**—When a patient’s hospital stay has been non-certified there are alternatives available to a hospital rather than discharging the patient from the hospital. Alaska Medicaid has provided two different programs for hospitals, the Swing Bed and the Administrative Wait Day(s) program, depending on whether the facility has been designated as a rural or urban hospital.

Rural hospitals may apply to the Division of Health Care Services to be an Alaska Medicaid Swing Bed provider. Once a hospital has been enrolled by Alaska Medicaid as a Swing Bed provider, they can request reimbursement for the days the patient remains in the hospital beyond Qualis Health’s non-certification.

Urban hospitals may apply to the Division of Health Care Services to be an Alaska Medicaid provider that may request Administrative Wait day(s). When a hospital is
enrolled in Alaska Medicaid they may request Administrative Wait day(s) reimbursement for a hospital stay where the patient remains in the hospital beyond Qualis Health’s non-certification.

Requests for Administrative Wait Day(s) or Swing Bed authorization must be submitted on a Long Term Care (LTC) Authorization form to the Division of Senior and Disabilities Services (DSDS).

**Leave of Absence**

According to the rules and regulations for the Alaska Division of Health Care Services *(Regulatory Reference: 7AAC 140.315(b)(4) Non-Compensable Hospital Care)*, a recipient that is absent from a facility for greater than 24 hours shall be considered discharged. There are two types of leave of absence:

1. **Less Than 24-Hour Pass**—If the pass has been ordered by the attending physician, it will be considered a covered benefit and therefore will be paid by the Alaska Division of Health Care Services, as long as the day of the pass has been deemed medically necessary by Qualis Health.

2. **Greater Than 24-Hour Pass**—The attending physician may have ordered the pass; however, it is not considered a covered benefit, according to the rules and regulations, for the Alaska Division of Health Care Services. This is considered the day of discharge and, therefore, will not be paid by the Alaska Division of Health Care Services.

**Notifying Qualis Health of a Leave of Absence**—The following procedures should be followed to notify Qualis Health of a leave of absence:

1. **Less Than 24-Hour Pass**—The facility’s Utilization Review Department should notify Qualis Health of any less than 24-hour passes during the concurrent review process.

2. **Greater Than 24-Hour Pass**—The attending physician may determine that a therapeutic pass is medically indicated. The Utilization Review Department is responsible for notifying Qualis Health prior to or after a greater than 24-hour pass has occurred for cases requiring Qualis Health review.

In order to accurately reflect the non-covered hospital days, a new case must be initiated by Qualis Health each time a recipient returns from a pass greater than 24 hours. This will result in issuance of a new case ID number by Qualis Health. Consequently, the Finance Department of each facility will need to submit a separate billing to the Alaska Division of Health Care Services fiscal agent to
coincide with each Qualis Health Case ID number and the respective admit and discharge dates.

This policy also applies to any pass situations greater than 24 hours identified by clinical reviewers performing chart reviews (retrospective reviews).

**Timeframes**

The timeframes for completion of reviews are as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent Review—Urgent</td>
<td>Three (3) calendar days</td>
</tr>
<tr>
<td>Concurrent Review—Non-Urgent</td>
<td>Three (3) calendar days</td>
</tr>
</tbody>
</table>

When additional information is required to complete the review, the timeline is adjusted accordingly. Qualis Health may choose to exercise a single extension of up to 15 calendar days on non-urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is only allowed on non-urgent reviews; it is not allowed for urgent care reviews.
Section 11–Physical Rehabilitation Utilization Reviews

Purpose
Care management best practice has found that the most effective form of review takes place before the recipient enters the rehabilitation facility. The chief advantage is that medically unnecessary rehabilitation stays can be avoided.

Responsibility
The facility utilization review department is responsible for the identification of Medicaid cases that require physical rehabilitation review. The attending physician is ultimately responsible for obtaining certification of inpatient physical rehabilitation admissions; however, Qualis Health also will accept telephone calls from the facility utilization review department.

Requirements
All physical rehabilitation services must be provided in State-certified or Medicare-approved rehabilitation units.

Process and Procedures
Operational hours for Alaska Medicaid review are:

5:30 a.m. to 4:45 p.m. Alaska Time (6:30 a.m. to 5:45 p.m. Pacific Time),
Monday through Friday

The physician or designated personnel may submit the review request for physical rehabilitation review to Qualis Health via iEXCHANGE (preferred method), or by phone, fax, or mail.

<table>
<thead>
<tr>
<th>How to Reach Qualis Health</th>
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<tbody>
<tr>
<td><strong>iEXCHANGE</strong></td>
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<tr>
<td><strong>Phone</strong></td>
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<tr>
<td><strong>Fax</strong></td>
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<td><strong>Mail</strong></td>
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</table>

Pre-service review for rehabilitation has two components—assessment and evaluation.
1. Assessment of a recipient’s rehabilitation potential—Before a recipient is admitted to the rehabilitation facility or unit specifically for rehabilitative care, Qualis Health must assess the following elements:

- Medical condition and history
- Functional limitations
- Prognosis
- Possible need for corrective surgery
- Attitude toward rehabilitation
- Ability to learn, meet rehabilitation goals and participate in 3 hours of therapy 5 days per week
- The existence of any social problems affecting rehabilitation
- Expected outcome(s) from rehabilitation treatment

Reasonable rehabilitation goals should be identified for the Qualis Health evaluation. The plan of care should include both short- and long-term goals.

2. Evaluation of Rehabilitation Program—Evaluation of the weekly multi-disciplinary rehabilitation team documentation will be reviewed during the next scheduled concurrent review, including:

- Physical, occupational, and/or speech therapy that total three hours per day, five days per week. (Medical reasons or complications precluding this criterion must be documented.)
- Any of the following services as indicated:
  - Medical/social services
  - Psychology
  - Recreational therapy
  - Vocational counseling
- Skilled rehabilitative nursing care or supervision required and available on a 24–hour basis.
- Documentation of measurable weekly improvement in functional in at least one therapy, and revision of goals if necessary.

The pre-service review may be conducted by the rehabilitation facility (i.e., physician or staff). **It is recommended that the call is initiated at least one week prior to a planned rehabilitation admission or preferably as soon as admission to a rehabilitation unit is anticipated.**
A sample copy of the Physical Rehabilitation Review Worksheet for Pre-service Review is included as Exhibit 12 to assist in collecting the necessary information for review.

**Information Needed for Review**—The Qualis Health representative will collect the following information for those reviews requiring pre-service review:

- Recipient name
- Recipient birth date
- Complete recipient address
- Sex of recipient
- Recipient Medicaid ID number
- Admitting diagnosis and ICD–9–CM code
- Physician name
- Physician address
- Physician phone number
- Physician Medicaid provider number
- Facility name
- Facility address
- Facility phone number
- Facility Medicaid provider number
- Current principal diagnosis and ICD–9–CM code
- Relevant surgeries including the ICD–9–CM and/or CPT code(s)
- Justification for the hospitalization and/or recipient symptoms
- Treatment proposed/provided
- Admission date

**Medical Necessity Screening**—Once the information for the review has been received, the Qualis Health clinical reviewer will assess the medical information using InterQual criteria to determine whether the condition of the recipient meets the Severity of Illness and Intensity of Service requirements for the level of care and the type and number of services requested. If the InterQual Severity of Illness and Intensity of Service screening criteria are met, the Qualis Health clinical reviewer will issue a Case ID number and the review will be certified. A length of stay will be determined and we will establish the date when a concurrent review will be conducted if the recipient has not been discharged.

Qualis Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered.
Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Alaska.

**Second-level Peer Review**—Cases that do not meet criteria are referred for clinical peer review by a Qualis Health physician reviewer (medical director or P/PC). The physician reviewer will review the clinical information and either certify the admission or issue a potential non-certification. In the event of a potential non-certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician reviewer. If a peer-to-peer conversation is requested, our physician reviewer and the recipient’s attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion, Qualis Health will either certify or non-certify the admission. See Section 3, Questions #2 and 3 for more information about the peer-to-peer conversation, including the time constraints involved in holding the conversation.

**Non-certifications**—If the Qualis Health physician reviewer non-certifies the admission, a Qualis Health representative will notify the appropriate provider (e.g., attending physician, facility) by telephone or iEXCHANGE®. We will also send non-certification letters within one working day to the following parties: the recipient, attending physician, facility, and the Department.

The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health’s initial non-certification determination. Refer to Section 15 of this manual for a detailed description of the appeal procedure.

The Department will not reimburse providers for services that have been non-certified by Qualis Health, with the exception of non-certifications that are reversed as a consequence of an appeal review by Qualis Health or a provider appeal or recipient fair hearing by the State.

**Physical Rehabilitation Transfer Reviews**

**Definitions**

There are two types of transfers—intra-facility and inter-facility—that require physical rehabilitation pre-service review.

- **Intra-Facility Transfer** is a transfer from a medical/surgical unit in a facility to a physical rehabilitation unit within the same facility. A review is not required for transfers to other types of medical/surgical units (i.e., ICU, CCU, etc.) within the same facility.

- **Inter-Facility Transfer** is a transfer from one inpatient facility to another inpatient facility. The receiving facility will initiate a new review for each inter-
facility transfer. Thus, each facility will have a unique certification number to use on the UB-04 claim form.

**Purpose**
The purpose of a transfer review is to ensure that all the Alaska Division of Health Care Services recipients receive the most appropriate level of care within the acute care facility.

**Special Requirements**
- Scheduled or non-urgent/emergent transfers to a physical rehabilitation unit should be pre-certified before the recipient is transferred to the unit
- Urgent or emergent transfers should be pre-certified by calling Qualis Health within 24 hours or one business day of the transfer
Section 12–Retrospective Utilization Review for Retroactive Eligibility

Definition and Purpose
A retrospective review is a review for medical necessity after services have been rendered and eligibility has been established. While a retrospective review may not be the most advantageous, this type of review is necessary to determine medical necessity of services already provided. A review of a facility confinement that is conducted after the recipient has entered the hospital or has been discharged from the hospital can result in non-certified hospital days or procedures/treatments. However, retrospective reviews are necessary for Medicaid recipients when eligibility is established retroactively.

Responsibility
The facility utilization reviewer is responsible for reviewing each chart for the appropriate information required prior to calling the Seattle office of Qualis Health for any retrospective review of inpatient stays less than 15 days. For a hospital stay 15 days and greater, the facility is responsible for submitting a complete legible copy of the entire medical record to Qualis Health.

Requirements
Retroactive eligibility review is required only for those outpatients or inpatient hospitalizations where the primary diagnosis or procedure would have required pre-service review or the hospitalization exceeded three days. Retroactive eligibility review applies to those recipients who were not Medicaid eligible at the time of admission and Medicaid eligibility was established at a later date.

For recipients who make application for Medicaid during an inpatient stay and subsequently become Medicaid eligible prior to discharge, providers are required to notify Qualis Health by telephone as soon as it is known the recipient is Medicaid eligible and a review is required. Qualis Health will proceed with performing certification review if the recipient is in the facility and eligibility has been established after admission but before discharge. This type of review is known as a Retrospective Pre-Discharge Review.

Days prior to eligibility being established will be reviewed retrospectively via telephone if the length of stay is less than 15 days or will be reviewed via chart if the length of stay is 15 days and greater. If the length of stay is 15 days and greater, a complete legible copy of the entire medical record is to be mailed to Qualis Health’s Seattle office for review.
For Medicaid recipients with retroactive eligibility established after discharge from an inpatient stay or after an outpatient procedure, the facility must request a Retrospective Review. When submitting a retrospective review by fax or mail, a Retrospective Review Request Form (refer to Exhibit 14) must be completed and submitted with a copy of the UB-04, history and physical, discharge summary and operative report, if applicable, for stays less than 15 days. Submit Retrospective Review Request Form to:

Qualis Health
Attn: Care Management Department/Retrospective Review
PO Box 33400
Seattle, WA 98133

Allow five (5) business days for processing before calling Qualis Health to complete the telephonic review. For stays 15 days and greater, the Retrospective Review Request Form must be completed and submitted with a copy of the UB-04, and a complete legible copy of the entire medial record.

For concurrent hospital days where the facility failed to obtain continued stay review authorization in a timely manner and the patient has not been discharged Qualis Health will process the review as a concurrent review. However, if the facility failed to obtain continued stay review authorization in a timely manner and the patient has been discharged, the facility should initiate a Retrospective Late Concurrent Review. If the review is less than 15 days it will be performed telephonically. If the review is 15 days or greater a chart review will be completed.

If the fiscal agent has denied claims for physician services because a prior authorization has not been obtained, the physician’s office personnel should contact the facility utilization review department to inquire whether a retrospective review has been requested. All requests should be initiated by the facility.

After reviewing the Retrospective Review Form or the iEXCHANGE® submission sent by the facility for retrospective reviews less than 15 days, Qualis Health will make a determination and notify the facility of that determination by phone or fax, or via iEXCHANGE®. Possible determinations include:

1. No additional review is necessary because Qualis Health previously reviewed and certified the procedure or diagnosis. If this is the case, the facility should
insert the Case ID number given by Qualis Health on the claim form, and then send the claim to the fiscal agent for processing.

2. The review is non-certified because the recipient was not eligible at the time of service and/or the services were not billed within the one year claim submission limitation.

3. The recipient had Medicare Part A as their primary coverage at the time of service.

4. The service is not a covered benefit or does not require review by Qualis Health.

Process and Procedures
Operational hours for Alaska Medicaid review are:

5:30 a.m. to 4:45 p.m. Alaska Time (6:30 a.m. to 5:45 p.m. Pacific Time),
Monday through Friday

The physician or designated personnel may submit the retrospective review request to Qualis Health via iEXCHANGE®, (preferred method), or by phone, fax, or mail.

<table>
<thead>
<tr>
<th>How to Reach Qualis Health</th>
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<tbody>
<tr>
<td><strong>iEXCHANGE</strong></td>
</tr>
<tr>
<td><strong>Phone</strong></td>
</tr>
<tr>
<td><strong>Fax</strong></td>
</tr>
</tbody>
</table>
| **Mail** | Qualis Health  
Attn: Care Management Department/Retrospective Review  
PO Box 33400  
Seattle, WA 98133-0400 |

Outpatient procedures and facility confinements of less than 15 days will need a copy of the UB-04, History and Physical, Discharge Summary, and Operative Report, if applicable, to be submitted with the retrospective review request. This information should be faxed or mailed to Qualis Health’s Seattle office with the completed Retrospective Review Request Form.
Submitting Retroactive (Retro) Eligibility Reviews <15 Days Via iEXCHANGE—Providers may submit retro <15 day reviews for medical/surgical reviews via iEXCHANGE. There is no need to submit the UB-04 form, a history and physical, or a discharge summary. You should include sufficient information for the clinical reviewer to complete the review. No day-by-day account is required. Document the following information in the Communication field:

- Retro <15 day review
- Admit and D/C date
- Previous Case ID# (if applicable)
- Contact Name and Phone Number
- It is necessary to include that you verified Medicaid eligibility

Providers may not submit the following Retro reviews via iEXCHANGE:

- Lengths of stay 15 days or greater; these continue to require submission of the entire medical record
- Reviews with a length of stay start date more than 365 days in the past are ineligible to be submitted via iEXCHANGE; an error message will display

Providers may either submit clinical information via the Web or with the faxed retrospective review request form or providers may call to provide the clinical information five days after submitting the retrospective review request form to Qualis Health.

Submitting Retroactive Eligibility Reviews 15 Days and Greater—For retroactive eligibility reviews where the length of stay is 15 days and greater, a complete legible copy of the entire medical record must be mailed to Qualis Health’s Seattle office with the completed Retrospective Review Request Form and a copy of the UB-04. In addition to review for medical necessity and appropriateness, these reviews will include screening for potential quality of care concerns. See Section 13 for more information.

Retrospective Review: Chart Requests—Occasionally when performing reviews by telephone, Qualis Health may request the chart of a recipient to verify quality of care or accuracy of the information provided. The chart request may be made either telephonically or in writing. The review determination rendered as a result of a chart review will always take precedence over a telephonic review determination.
**Medical Necessity Screening**—The Qualis Health clinical reviewer will review the information provided for the retrospective review and will apply InterQual criteria. If the InterQual criteria are met, Qualis Health will issue a Case ID number. Qualis Health certification indicates that the admission is medically necessary. The fiscal agent for the Department will be notified by electronic data transfer of the determination.

If the recipient is still in the facility at the time of the initial retroactive eligibility review, the review will be conducted according to concurrent review format.

**Second-level Peer Review**—Cases that do not meet criteria are referred for clinical peer review by a Qualis Health physician reviewer (medical director or P/PC).

**Non-certifications**—If the Qualis Health physician reviewer non-certifies the admission, a Qualis Health representative will notify the appropriate provider (e.g., attending physician, facility) by telephone or iEXCHANGE®. Since a copy of the medical record is reviewed for a chart review, a peer-to-peer conversation is not offered as all pertinent information regarding the admission is recorded in the medical record and will have been reviewed.

Qualis Health will send non-certification letters within one working day to the following parties: the recipient, attending physician, facility, and the Department. The non-certification letters will contain justification for the non-certification and an explanation of the right to request an appeal of Qualis Health’s initial non-certification determination. The Department’s fiscal agent will be notified by electronic data transfer.

**Timeframes**

The timeframe for completion of reviews is as follows:

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Time Frames for Completion from Date of Notification to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective Review</td>
<td>Thirty (30) calendar days</td>
</tr>
</tbody>
</table>

When additional information is required to complete the review, the timeline is adjusted accordingly.
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Section 13–Potential Quality of Care Concerns

Overview

Qualis Health is committed to promoting optimum quality of care for all recipients and therefore will assess quality of care in various settings while performing reviews. The facility and attending physician are responsible for delivering the utmost quality of care for their patients. The Qualis Health clinical reviewer is responsible for identifying potential quality of care concerns regarding Alaska Division of Health Care Services recipients. Potential quality of care concerns may be identified during all types of reviews, including retrospective chart reviews.

If the Qualis Health clinical reviewer identifies a potential quality of care concern when performing a review, the situation will be handled in one of two ways:

- If the clinical reviewer determines that the recipient’s quality of care is currently being compromised, a Qualis Health physician (medical director or P/PC) will be consulted. If the Qualis Health physician concurs that there is a potential quality of care concern, Qualis Health will refer the case to the Alaska Division of Health Care Services for further action. In addition, our clinical reviewer will notify the facility utilization review department and request that the attending physician call the Qualis Health physician reviewer to discuss the case. This will provide an opportunity to clarify and/or discuss other treatment options or interventions.

- If the clinical reviewer determines that there is a potential quality of care concern, but the recipient’s care is not currently being compromised, a Qualis Health physician (medical director or P/PC) will be consulted. If the Qualis Health physician concurs that there is a potential quality of care concern, Qualis Health will refer the case to the Alaska Division of Health Care Services for further action.
Section 14–Special Case Utilization Reviews

Purpose
Special case reviews for Medicaid recipients may be reviewed at any time at the direction of the Department. Special case reviews may include a variety of treatment and or procedure reviews particularly those that are potentially non-covered or experimental/investigational in nature.

Responsibility
When the Department has approved a Special Case Review, facilities will be notified in writing to send those records associated with the reviews.

A complete legible copy of the entire medical record and additional information requested is to be mailed by the facility to Qualis Health’s Seattle office at the following address:

Qualis Health
Attn: Care Management Department/Special Case Review
PO Box 33400
Seattle, WA 98133-0400

Requirements
The facility is to submit a complete legible copy of entire medical record to Qualis Health within 30 days of receipt of notification of the case requested for review.

Process and Procedures
Qualis Health will report the result of the review to the Department only. Notification to other parties will be at the direction of the Department.
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Section 15–Utilization Review Appeals

Overview

Qualis Health offers an appeal process in all cases involving an adverse determination. When a review determination is to deny, reduce, or terminate covered services, Qualis Health will generate written notification of the adverse decision within one business day of the date the decision is made. Our non-certification notification will include rights for an appeal review. Qualis Health’s appeal process features a second opinion by a physician who specializes in the services under review. URAC requires that appeal reviews be conducted by individuals who:

- Are clinical peers
- Hold an active, unrestricted license to practice medicine or a health profession
- Are board-certified by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists
- Are in the same profession and in a similar specialty as typically manages the medical condition, procedure, or treatment under appeal
- Are neither the individual who made the original non-certification nor the subordinate of such an individual
- Have no conflicts of interest with the patient, attending physician, or facility being reviewed

There are two types of appeals potentially available—expedited or standard. Instructions on how to initiate each type of appeal are included in the non-certification letter Qualis Health sends when the adverse determination is made.

Expedited Appeals

**Definition**

An expedited appeal is an appeal of a non-certification in a case involving urgent care.

**Process and Procedures**

A request for an expedited appeal may be made by telephone, fax, or mail within two business days of the receipt of the non-certification notification if the recipient has not yet been discharged. If an expedited appeal request is filed after two business days, Qualis Health will respond to that request through the standard appeal process.

Expedited appeals for the Alaska Medicaid pre-service and concurrent review programs will be conducted by care management staff in Qualis Health’s Seattle office. Requests for expedited appeals should be directed as follows:
How to Request an Expedited Appeal

<table>
<thead>
<tr>
<th>Call</th>
<th>1-800-783-9207</th>
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<tbody>
<tr>
<td>Fax</td>
<td>1-800-826-3630</td>
</tr>
<tr>
<td>Write</td>
<td>Qualis Health</td>
</tr>
<tr>
<td></td>
<td>Attn: Care Management Department/Appeal Review</td>
</tr>
<tr>
<td></td>
<td>PO Box 33400</td>
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<tr>
<td></td>
<td>Seattle, WA 98133-0400</td>
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</tbody>
</table>

Upon receipt of the request for an expedited appeal, the following will occur:

1. Qualis Health will notify all appropriate parties of the request.
2. Qualis Health will, if needed, request that any additional medical information (i.e., medical records and/or physician office notes) necessary for the appeal review be submitted to us within two hours.
3. The case will be referred to a Qualis Health physician/practitioner consultant (P/PC) licensed and/or accredited in the appropriate specialty or subspecialty who is not the same individual who initially reviewed and non-certified the review.
4. The P/PC will review the medical information.
5. If the P/PC reverses the non-certification decision, the Qualis Health representative will issue a Case ID number and length of stay (if applicable) and will notify all appropriate parties telephonically and in writing.
6. If the P/PC modifies the decision or upholds the non-certification, the requesting physician or facility will be notified telephonically and in writing.
7. The Department’s MMIS will be updated electronically accordingly if decision is either reversed or modified.
8. Notification with the review outcome, including clinical rationale will be sent to the recipient, attending physician, and facility.

If the recipient, attending physician, or facility disagrees with the expedited outcome, the standard appeal process may be followed.
Standard Appeal

**Definition**
A standard appeal is an appeal of a non-certification that is not an expedited appeal. In most cases, standard appeals will not relate to cases involving urgent care. However, standard appeals may also include secondary appeals of expedited appeals.

**Process and Procedures**
A request for a standard appeal may be made by telephone, fax, or mail within 180 days of the date shown on the non-certification notice. Standard appeals for the Alaska Medicaid pre-service and concurrent review programs will be conducted by care management staff in Qualis Health’s Seattle office. Requests for standard appeals should be directed as follows:

<table>
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<tr>
<th>How to Request a Standard Appeal</th>
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<tr>
<td>Call</td>
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<tr>
<td>1-800-783-9207</td>
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<tr>
<td>Fax</td>
</tr>
<tr>
<td>1-800-826-3630</td>
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<tr>
<td>Write</td>
</tr>
<tr>
<td>Qualis Health</td>
</tr>
<tr>
<td>Attn: Care Management Department/Appeal Review</td>
</tr>
<tr>
<td>PO Box 33400</td>
</tr>
<tr>
<td>Seattle, WA 98133-0400</td>
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</tbody>
</table>

Any request for appeal of a non-certification will be reviewed by a Qualis Health physician/practitioner consultant licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician but will not be the same individual(s) who initially non-certified the review or the expedited appeal, if applicable.

Qualis Health will issue the appeal decision within 30 days of receipt of the request for a standard appeal. All appropriate parties will be notified in writing of Qualis Health’s determination to uphold, reverse, or modify the initial non-certification decision.

Qualis Health’s appeal decision will take precedence over the initial non-certification decision or the expedited appeal decision, if applicable. For example, if the appeal review certifies more facility days than the original review, then more facility days will be recommended for certification. Conversely, if the appeal review certifies fewer days than the original review, then fewer facility days will be recommended for certification. Refer to Exhibit 4, Standard Appeal Process Flow Chart.
Division of Health Care Services Appeal Procedure

**Fair Hearing Rights for Recipients**

The Alaska Division of Health Care Services Fair Hearing procedure is the process by which recipients can contest the Qualis Health non-certification decision. Recipients may request a fair hearing by phone or in writing to the Fair Hearing representative at Alaska Division of Health Care Services, within 30 days of the date on Qualis Health’s standard appeal determination letter non-certifying the service. The request must state the rationale for requesting a Fair Hearing. The address and phone number to request a fair hearing:

**Fair Hearing Representative**

Alaska Division of Health Care Services

4501 Business Park Blvd, Suite 24

Anchorage, AK 99503-7167

Phone: 907-334-2400

If the recipient has been getting a service paid by Alaska Division of Health Care Services that is stopped, suspended, or reduced by an action we take, the recipient may ask that the service be continued. If the recipient wants to have the service continued while awaiting a hearing decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or reduce the service. If the recipient asks for the service to be continued and the hearing decision determines that the Alaska Division of Health Care Services was correct to stop, suspend, or reduce the service, the state may require the recipient to repay the cost of the services provided. *(Regulatory References: 42 CFR 431.230(b) and 7 AAC 49.200)*

**Second Level Appeal Rights for Providers**

An additional appeal process is available to providers through the Alaska Division of Health Care Services. A provider may request a second level appeal when they are not satisfied with the results of the first level appeal decision by Qualis Health. A second level appeal must be requested in writing and postmarked within 60 days of the date of the first-level appeal decision by Qualis Health. A telephone call does not serve as notification that a second level appeal is being requested. Providers should submit second level appeals to:

**Claims Appeal Representative**

Alaska Division of Health Care Services

4501 Business Park Blvd., Suite 24

Anchorage, AK 99503-7167

Include a copy of the Qualis Health first level decision and supporting documentation considered relevant with the written appeal request.
Providers will be notified in writing of the final decision by the Alaska Division of Health Care Services. If the recipient has been getting a service paid by the Alaska Division of Health Care Services that is stopped, suspended, or reduced by an action we take, the recipient may ask that the service be continued. If the recipient wants to have the service continued during the time awaiting an appeal decision, he/she should ask for a continuation of the service within 10 days of the date of the action to stop, suspend, or reduce the service. If the recipient asks for the service to be continued and the appeal decision determines that the Alaska Division of Health Care Services was correct to stop, suspend, or reduce the service, the state may require the recipient to repay the cost of the services provided. *(Regulatory References: 42 CFR 431.230(b), 42 CFR 431.231(a), 7 AAC 49.190 and 7 AAC 49.200)*
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Section 16-Case Management

Definition and Compliance with URAC

URAC defines case management as a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality and cost effective outcomes. Qualis Health complies with URAC case management (CM) standards when performing case management services. Qualis Health’s URAC accredited case management program provides a combination of assessment, coordination, recommendation, education, and support for Alaska Medicaid recipients with medically complex conditions and long-term and/or costly health care needs.

Purpose

Case management is focused on helping medically complex patients—and those who are expected to be long-term patients—to receive appropriate medical services in a cost-effective manner. A comprehensive care plan is developed in collaboration with the patient (recipient) and the patient’s family, attending physician, and other health and social service providers. This care plan will address the patient’s needs in the most appropriate manner.

In addition to working with the recipient/family, physician, and other medical providers to develop a coordinated care plan, Qualis Health’s case management program for Alaska Medicaid includes the following types of activities:

- Assessing the recipient’s personal situation and challenges
- Providing information, resources, and referrals to support treatment
- Coordinating services provided by health care professionals involved in the recipient’s medical treatment
- Coordinating the services of agencies
- Pre-admission monitoring
- Discharge planning

Special Considerations

Qualis Health provides cases management services for Alaska Medicaid from our Alaska and Washington offices. We use Anchorage- and Fairbanks-based case managers to better serve the unique needs of the Alaska population, but also have Seattle-based case managers to coordinate cases needing specialized services in the Seattle area.
The following special considerations apply to the case management program Qualis Health provides for Alaska Medicaid:

- Case management is a voluntary program for recipients. All recipients who agree to participate in case management will be asked to sign a release of information indicating their willingness to participate in the case management process.
- Alaska Medicaid recipients are eligible for case management services regardless of location.
- Recipients who are on the Alaska Medicaid Waiver, TEFRA, and Breast and Cervical Cancer Programs are eligible to participate in case management.
- Case management services are, for the most part, provided telephonically, but also include site visits.

**Targeted Cases**

Qualis Health has the computer system capability to automatically route utilization management cases that have a condition or diagnosis on a “Case Management Referral Triggers” list. These potential cases are referred to case managers for case management screening. The types of cases often found in case management are as follows:

- High cost cases targeted by Utilization Review (i.e. long lengths of stay, frequent emergency and inpatient admissions)
- Patients with complex coordination and planning needs that include services such as Durable Medical Equipment, Home Health Care, Wound Care and Pharmacy
- Admissions with length of stay greater than 5 days
- Burns/Wounds/Non–healing Ulcers
- Cancer
- Cardiovascular Disease
- Chronic Respiratory Disease
- Complicated Pregnancy
- Congenital Defects
- Congenital Heart Disease
- High Risk Pregnancy
- HIV/AIDS
- Mental Health Conditions
- Multiple Medical Conditions
- Neonate less than 33 weeks or with complications
- Neurodegenerative Disorders (ALS, MS, MD)
- Neurological Conditions (Aneurysm, Meningitis, Encephalitis, etc.)
Organ and bone marrow/stem cell transplants
Possibility of Severe Permanent Impairments
Rehabilitation
Re–hospitalizations and Multiple Treatments that have occurred or are planned
Spinal Cord Injuries
Traumatic Brain Injury
Traumatic Injuries (Multiple Trauma, Amputation, etc.)
Wound Management

**Process and Procedures**

**Case Identification**

While many referrals to case management occur through the utilization management process, cases can be identified and referred from multiple sources, including: patient self-referral, physician or other provider, discharge planner, care coordinator, Alaska Medicaid, and other state agencies. Currently, Qualis Health screens referrals utilizing criteria established in conjunction with the Department. Cases are screened by case managers and involved parties and facilities are then notified of case management services. Qualis Health accepts any referral. For your convenience see Exhibit 15, Case Management Referral Form.

**Opening a Case**

Once a case has been screened and found to meet case management criteria, the recipient/family are provided the opportunity to participate in case management, and with their consent, a case is opened with further assessment performed. A case manager will begin the initial case management process, which includes:

- Gathering information to help identify the best health care for the recipient
- Making recommendations regarding the recipient’s health care needs
- Informing health care team members about benefits and available resources
- Coordinating referrals and assisting in obtaining appropriate health care services

An initial report listing case management interventions, goals, and recommendations is submitted to Alaska Medicaid. Status update reports are provided on an ongoing basis.
Provider Interface

The case manager will notify the attending physician and involved health care providers, when necessary, of the recipient’s participation in case management. The case manager will work collaboratively with all health care providers to assure all services are appropriate and medically necessary.

Certification (Prior Authorization) Requirements

The fiscal agent currently receives and processes requests for all services requiring prior authorization. For Qualis Health case managed patients, the following services must be certified by a case manager at Qualis Health. This will result in a certification/prior authorization (PA) number being issued.

- Home Health
- Private Duty Nursing
- Hospice
- Durable Medical Equipment (DME)

After Qualis Health has notified a provider that a specific recipient is under case management, it is the responsibility of the health care provider to obtain PA from Qualis Health. Refer to Section 2, Communications with Qualis Health for additional information.

If you are uncertain whether or not your patient is under case management, submit your PA request to the fiscal agent. If this patient is under case management, the fiscal agent will forward your requests to the Qualis Health case manager. However, requesting prior authorization from the wrong agency could potentially delay the processing of the prior authorization request. The Qualis Health case managers will notify providers of any patient for whom they have received requests.

Qualis Health Prior Authorization Determination Process

Providers should submit information to the Qualis Health case manager utilizing the DHCS prior authorization form. After reviewing the request, the case manager will use InterQual criteria and, as applicable, state-specific criteria and policy to either approve the request or refer it to a Qualis Health physician for second-level review. Qualis Health will inform the health care provider of the decision by telephonic confirmation. Qualis Health notifies the fiscal agent for the Alaska Division of Health Care Services of all decisions.
Prior Authorization Certification
The Qualis Health PA process has three components:

1. Review all types of services for medical necessity
2. Review the length of services for medical necessity
3. Review usage of benefits for appropriateness

For those recipients under case management Qualis Health follows the same PA process for services as is required by DHCS policy for home health nursing, private duty nursing, hospice and select DME. For DHCS policy consult the “Alaska Medical Assistance Provider Manual” for the service requested.

Case Closure
Once it is determined that case management services are no longer indicated (i.e., patient’s medical condition stable and all appropriate services in place, no ongoing needs), the case will be reviewed for closure. The recipient will be notified by phone or correspondence that the case is being closed. Satisfaction Questionnaires are regularly sent to recipient or family at the time of case closure.

Integrated Utilization Management (UM) and Case Management (CM) Program
Qualis Health has adopted integrated UM/CM services for select cases that include the following complex case types:

- Inpatient rehabilitation cases
- Neonatal cases

For those recipients in the above populations who are in case management, Qualis Health’s case managers also provide the utilization review services, which means the case manager becomes the single point of contact and monitors both utilization management and case management services for the patient. Using a case manager for reviews provides a more comprehensive approach to coordination of services for complex cases and helps to ensure appropriate utilization of services. Through the integration of UM/CM services outcomes are optimized including increased provider satisfaction and increases in days saved per admission.
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Appendix A
Select Diagnoses and Procedures Pre-certification List
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## Appendix A
Select Diagnoses and Procedures Pre-certification List

**Effective January 1, 2011**

### DIAGNOSES/SYMPTOMS REQUIRING PRE-CERTIFICATION
FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD–9 CM Diagnosis Code</th>
<th>LOCATION</th>
<th>REVIEW METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenteritis</td>
<td>001.1, 002.0, 002.9, 003.0, 004.9, 005.0, 005.1, 005.9, 006.0 through 006.2, 006.9, 007.1, 007.2, 007.8, 007.9 008.00 through 008.04, 008.09, 008.1, 008.2, 008.3, 008.5, 008.8, 008.41 through 008.47, 008.49, 008.61 through 008.69, 008.8, 009.0, through 009.3, 014.80-014.86, 112.85, 487.8, 536.8, 556.0 through 556.9, 557.0, 557.1, 557.9, 558.1, 558.2, 558.3, 558.41, 558.9, 564.9, 569.9</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>682.0 through 682.9</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Respiratory Illness Bronchitis</td>
<td>466.0 through 466.19</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(Children under the age of five (1825 days) are excluded from pre-certification. Continued Stay Review is required after day 3, as are all hospital stays.)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>480.9 through 486</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>(Children under the age of five (1825 days) are excluded from pre-certification. Continued Stay Review is required after day 3, as are all hospital stays.)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Physical Rehabilitation</td>
<td>V57.0, V57.1, V57.21, V57.22, V57.3, V57.4, V57.81, V57.89, V57.9</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>All Admissions to Long Term Acute Care Facilities (LTAC)</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medical admits for psychiatric reviews NOT Reviewed by the Alaska Medicaid Behavioral Health Staff</td>
<td>290.00-316.00</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

All categories on this page require the facility’s Utilization Review Department to notify Qualis Health of urgent/emergent admits within 24 hours or the next business day. The attending physician is responsible for pre-certifying any non-urgent/emergent admissions for the above diagnoses/symptoms.
## PROCEDURES REQUIRING PRE–CERTIFICATION FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD–9 CM Procedure Code</th>
<th>CPT® Code</th>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
<th>TELEPHONIC/FAX</th>
<th>CLINICAL RECORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Detoxification</td>
<td>94.62</td>
<td>90899</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Drug Detoxification</td>
<td>94.65</td>
<td>90899</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Combined Alcohol &amp; Drug Detoxification</td>
<td>94.68</td>
<td>90899</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Cochlear device implantation</td>
<td>20.95, 20.96, 20.97, 20.98, 20.99</td>
<td>69930</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cranial implantation or replacement of neurostimulator pulse generator</td>
<td>01.20</td>
<td>**</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gastric Bypass for Obesity</td>
<td>44.31</td>
<td>43644, 43645, 43775, 43845, 43846, 43847, 43848, 43850, 43886, 43887, 43888, 47740, 47741</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Laparoscopic Gastroplasty/Gastric Bypass</td>
<td>44.68</td>
<td>43645, 43843</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Gastric Adjustable Band</td>
<td>44.95</td>
<td>43845, 43770, 43771, 43772, 43773, 43774, 43842</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Duodenal Switch</td>
<td>43.89, 45.91</td>
<td>43845</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
| Hysterectomy (All Hysterectomies must have informed consent and meet the following criteria:  
  • Patient must be over 21 years of age  
  • Patient must be mentally competent) |                          |                    | ✓         | ✓          | ✓              | ✓               |
<p>| Abdominal                                      | 68.39, 68.49, 68.69     | 58150, 58152, 58180, 58200, 58951, 58953, 58954, 58956, 59135, 59525 | ✓         | ✓          | ✓              | ✓               |
| Vaginal                                        | 68.51, 68.59, 68.71, 68.79 | 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294 | ✓         | ✓          | ✓              | ✓               |
| Laparoscopic                                   | 68.31, 68.41, 68.51, 68.61, 68.71 | 58550, 58552, 58553, 58554, 58207, 58541, 58542, 58543, 58544, 58545, 58548, 58570, 58571, 58572, 58573, 58574, 58575, 58578 | ✓         | ✓          | ✓              | ✓               |
| Radical                                        | 68.8                    | 58210, 58240, 58548 | ✓         | ✓          | ✓              | ✓               |
| Laminectomy/Diskectomy                         | 03.02, 03.09, 80.50, 80.51 | 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295 | ✓         | ✓          | ✓              | ✓               |</p>
<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD–9 CM Procedure Code</th>
<th>CPT® Code</th>
<th>Location</th>
<th>Review Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division of intra–spinal nerve root–Rhizotomy</td>
<td>03.1</td>
<td>63185, 63190, 0090T, 0091T, 0092T, 0093T, 0095T, 0096T, 0098T</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Internal fixation of bone without fracture reduction</td>
<td>78.59</td>
<td>22841</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Spinal Fusion (arthrodesis)</td>
<td>81.00 through 81.08, 81.30 through 81.39, 84.51, 84.52, 81.62, 81.63, 81.64</td>
<td>22585, 22614, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cervical including revision</td>
<td>81.01, 81.02, 81.03, 81.31, 81.32, 81.33</td>
<td>22548, 22554, 22590, 22595, 22600</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dorsal/Thoracic including revision</td>
<td>81.04, 81.05, 81.34, 81.35</td>
<td>22532, 22556, 22610</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Lumbar/Lumbosacral including revision</td>
<td>81.06, 81.07, 81.08, 81.36, 81.37, 81.38</td>
<td>22533, 22534, 22558, 22612, 22630</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Insertion of Spinal disc prosthesis</td>
<td>84.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revision or Replacement</td>
<td>84.69</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertion of partial spinal disc prosthesis</td>
<td>84.61</td>
<td>22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Insertion of total spinal disc prosthesis</td>
<td>84.62</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revision, Replacement or Removal</td>
<td>84.66</td>
<td>22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Dorsal/Thoracic</td>
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<td></td>
<td></td>
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<tr>
<td>Insertion of partial spinal disc prosthesis</td>
<td>84.63</td>
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<td></td>
<td></td>
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<tr>
<td>Revision or Replacement</td>
<td>84.67</td>
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<tr>
<td>Lumbar/Lumbosacral</td>
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<tr>
<td>Insertion of partial spinal disc prosthesis</td>
<td>84.64</td>
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<td></td>
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<tr>
<td>Insertion of total spinal disc prosthesis</td>
<td>84.65</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revision or Replacement</td>
<td>84.68</td>
<td>22851, 22852, 22855, 22857, 22862, 22864, 22865, 0090T, 0092T, 0163T</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Mastopexy</td>
<td>85.6, 85.70, 85.71, 85.72, 85.73, 85.74, 85.75, 85.76, 85.79</td>
<td>19316</td>
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<tr>
<td>Mastectomy</td>
<td>85.4, 85.41</td>
<td>19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Mammoplasty (reduction)</td>
<td>85.31 (unilateral)</td>
<td>19318</td>
<td></td>
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<tr>
<td>Mammoplasty</td>
<td>85.32 (bilateral)</td>
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<tr>
<td>Mammoplasty</td>
<td>85.5, 85.50</td>
<td>19324</td>
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</tbody>
</table>

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Updated with January 2010 codes.

**Will be updated with CPT codes when they become available.
### PROCEDURES REQUIRING PRE–CERTIFICATION FOR ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES MEDICAL ASSISTANCE RECIPIENTS

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD–9 CM Procedure Code</th>
<th>CPT® Code</th>
<th>LOCATION</th>
<th>REVIEW METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral injection to breast for augmentation</td>
<td>85.51</td>
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<tr>
<td>Bilateral injection to breast for augmentation</td>
<td>85.52</td>
<td>19324</td>
<td></td>
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</tr>
<tr>
<td>Unilateral prosthetic implant</td>
<td>85.53</td>
<td>11970, 19325, 19340, 19342</td>
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<tr>
<td>Bilateral prosthetic implant</td>
<td>85.54</td>
<td>19325, 19340, 19342</td>
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<tr>
<td><strong>Fat graft to breast</strong></td>
<td>85.55</td>
<td>**</td>
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<tr>
<td>Removal of prosthetic implant</td>
<td>85.94</td>
<td>19328, 19330</td>
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<tr>
<td>Revision of implant of breast</td>
<td>85.93</td>
<td>19342</td>
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<tr>
<td>Breast reconstruction with insertion of breast tissue expander</td>
<td>85.95</td>
<td>19357</td>
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<tr>
<td>Removal of breast tissue expander</td>
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<td>19357</td>
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<tr>
<td>Other</td>
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<td>19350, 19355, 19361, 19364, 19366, 19367, 19368, 19369, 19396</td>
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<td>Revision of reconstructed breast</td>
<td>85.53, 85.89</td>
<td>19342, 19380</td>
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<td>Unlisted procedure, breast</td>
<td>85.99</td>
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<td>Unilateral Subcutaneous mammectomy with implant</td>
<td>85.33</td>
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<td>Unilateral Subcutaneous mammectomy NEC</td>
<td>85.34</td>
<td>19304</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilateral Subcutaneous mammectomy with implant</td>
<td>85.35</td>
<td>19304</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other bilateral subcutaneous mammectomy</td>
<td>85.36</td>
<td>19304</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast DIEP Flap Reconstruction</td>
<td>85.85</td>
<td>82068</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panniculectomy/Abdominoplasty</td>
<td>86.83</td>
<td>15830, 15847</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Fat graft of skin and subcutaneous tissue</strong></td>
<td>86.87</td>
<td>**</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Extraction of fat for graft or banking</td>
<td>86.90</td>
<td>**</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total Knee Replacement</td>
<td>81.54</td>
<td>27440, 27441, 27442, 27443, 27445, 27446, 27447</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Revision of Knee Replacement</td>
<td>81.55, 81.59, 00.80, 00.81, 00.82, 00.83, 00.84</td>
<td>27486, 27487</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Menisectomy, Knee <em>(Inpatient only)</em></td>
<td>80.6</td>
<td>27332, 27333, 29880, 29881</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total Hip Replacement</td>
<td>81.51</td>
<td>27130</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Procedure</td>
<td>ICD–9 CM Procedure Code</td>
<td>CPT® Code</td>
<td>Location</td>
<td>Review Method</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>Revision–Total or Partial</td>
<td>81.53, 81.59, 00.70, 00.71, 00.72, 00.73, 00.74, 00.75, 00.76, 00.77, 00.85, 00.86, 00.87</td>
<td>27132, 27134, 27137, 27138</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Partial Hip Replacement</td>
<td>81.52</td>
<td>27125</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Total Ankle Replacement including revision</td>
<td>81.56, 81.59</td>
<td>27700, 27702, 27703</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Video/telemetric EEG Monitoring</td>
<td>89.19</td>
<td>95950, 95951, 95953, 95956</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
**IMPORTANT COVERAGE INFORMATION ABOUT TRANSPLANTS**

- Alaska Medicaid Regulations provide for limited coverage of transplants.
- All transplants must be medically necessary.
- Kidney/cornea/skin/bone transplants do not require preauthorization from Qualis Health.
- All other covered transplants listed below require preauthorization from Qualis Health.
- Multiple organ transplants including any of the procedures below require preauthorization.

**TRANSPLANTS NOT LISTED BELOW ARE NOT COVERED BY ALASKA MEDICAID.**

### Transplant Procedures Requiring Special Review

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD–9 CM Procedure Code</th>
<th>CPT® Code</th>
<th>LOCATION</th>
<th>REVIEW METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Marrow Transplant (includes stem cell transplant)</td>
<td>41.00, 41.01, 41.04, 41.07, 41.09</td>
<td>38241</td>
<td>✓ ✓ ✓</td>
<td>✓ ✓ ✓</td>
</tr>
<tr>
<td></td>
<td>Autologous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allogenic</td>
<td>41.02, 41.03, 41.05, 41.06, 41.08</td>
<td>38240, 38242</td>
<td></td>
</tr>
<tr>
<td>Liver Transplant (Cadaver)</td>
<td>50.51, 50.59</td>
<td>47135, 47136</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Liver Transplant (Living Donor)</td>
<td>50.59</td>
<td>47135, 47136</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Heart Transplant, including Artificial Heart (All ages covered, effective 8/26/08)</td>
<td>37.51, 37.52, 37.53, 37.54</td>
<td>33945</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lung Transplant (All ages covered, effective 8/26/08)</td>
<td>33.50, 33.51, 33.52</td>
<td>32851, 32852, 32853, 32854</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Heart/Lung Transplant (All ages covered, effective 8/26/08)</td>
<td>33.6</td>
<td>33935</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Other Surgical Procedures Requiring Special Review

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD–9 CM Procedure Code</th>
<th>CPT® Code</th>
<th>LOCATION</th>
<th>REVIEW METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastric Neurostimulator</td>
<td>04.92, 86.94</td>
<td>43647, 43648, 43881, 43882, 64590, 64595</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
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Appendix B
Glossary of Terms & Acronyms
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Appendix B
Glossary of Terms & Acronyms

**Administrative Wait Days:** Acute care bed in an urban facility where a patient can continue to receive care at a lower rate.

**Affiliated Computer Services, Inc.:** Fiscal agent for Alaska Division of Health Care Services.

**Call date or Call-back date:** Notification date or date the review is conducted (same as “Review Date” or “Scheduled Discharge Date”).

**Care Management Department:** Includes the telephonic, medical record review areas and case management services at Qualis Health.

**Case ID Number:** Qualis Health certification number assigned to each case certified; eight-digit number beginning with “88.” The last six digits are assigned by the Qualis Health computer. Number is used on all billing or claim forms for the fiscal agent to verify the pre-certification.

**Concurrent Review:** The process of reviewing for continued medical necessity.

**Disabled or Disability:** The inability to engage in substantial gainful activity by reason of a medically-determined physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. [Alaska Administrative Code AAC 48.598]

**Health Insurance Portability and Accountability Act:** Relating to the uses and disclosures of Protected Health Information.

**InterQual Criteria:** Evidence based clinical review criteria and guidelines which support first level clinical review by Qualis Health clinical reviewers.

**Intensity of Services:** InterQual Criteria component that means diagnostic and therapeutic services that can be provided only in a hospital.

**Non-certification:** Qualis Health decision not to authorize a service.

**Non-Urgent/Emergent Procedure:** Procedure that is subject to the choice or decision of the recipient or physician regarding medical services that are advantageous to the recipient but not necessary to prevent the death or disability of the recipient.

**Pre-service Review:** The process whereby Qualis Health reviews clinical information from the provider to determine medical necessity for specific services found on the Alaska Division of Health Care Services pre-certification list for recipients.

**Prior Authorization:** Authorization granted for services or medical procedures requiring prior review and approval by the State medical professionals (or designee), before such service can be performed and paid.

Cited: Alaska Medical Assistance Program Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, orthotics and Home Infusion Therapy Provider Billing Manual (updated 8/03).

**Provider:** An individual, firm, corporation, association, or institution providing or approved to provide medical services to an Alaska Division of Health Care Services recipient.

**Provider I.D. Number:** Number assigned to each provider by ACS, fiscal agent for Alaska Division of Health Care Services.

**Recipient:** An individual eligible for benefits under Alaska Division of Health Care Services.
**Retroactive Eligibility Review:** Review of cases for recipients not eligible at the time of admission and determined eligible at a later date.

**Retrospective Review:** All types of post-payment and/or post-admission review; recipient may or may not be eligible at the time of admission.

**Review Date:** Notification date or date review required (same as “Call Back Date” and “Scheduled Discharge Date”).

**Scheduled Discharge Date:** Notification date or date review required (same as “Review Date” or “Call Back Date”).

**Severity of Illness:** InterQual Criteria component that means objective clinical findings that define severity of illness.

**Swing Bed:** Acute care bed in a rural facility where a patient can continue to receive care at a lower rate.

**Urgent care services:** A case is considered to involve urgent care whenever the application of the time periods for making non–urgent care determinations (a) could seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function, or (b) in the opinion of a physician with knowledge of the recipient’s medical condition, would subject the recipient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

### Acronyms

**ACS:** Affiliated Computer Services, Inc.
**AWDs:** Administrative Wait Days
**CM:** Case Manager at Qualis Health
**CMS:** Centers for Medicare & Medicaid Services
**CPT:** Physicians’ Current Procedural Terminology
**DBH:** Division of Behavioral Health
**DHCS:** Division of Health Care Services
**DHSS:** Department of Health and Social Services, also known as the Department
**DME:** Durable Medical Equipment
**DOB:** Date of birth
**DPA:** Division of Public Assistance
**DS:** Discharge screening criteria indicative of patient stability and readiness for discharge
**DSDS:** Division of Senior and Disabilities Services
**HIPAA:** Health Insurance Portability and Accountability Act
**ICD-9-CM:** International Classification of Diseases (9th Edition, Clinical Modification)
**IS:** Intensity of Services
**LOC:** Level of Care
**LOS:** Length of Stay
**P/PC:** Physician/Practitioner Consultant at Qualis Health
**QIO:** Quality Improvement Organization
**SI:** Severity of illness
**TEFRA:** Tax Equity and Fiscal Responsibility Act of 1982
Appendix C
List of Key Contact Personnel for Qualis Health and Alaska DHCS
## Appendix C

Qualis Health Key Contact Personnel

<table>
<thead>
<tr>
<th>Care Management Department</th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>10700 Meridian Avenue North, Suite 100</td>
<td>741 Sesame Street, Suite 100</td>
</tr>
<tr>
<td>P.O. Box 33400</td>
<td>Anchorage, AK 99503</td>
</tr>
<tr>
<td>Seattle, WA 98133</td>
<td>Tel.: (888) 578-2547</td>
</tr>
<tr>
<td>Tel.: (800) 949-7536</td>
<td>(907) 770-7525</td>
</tr>
<tr>
<td>Fax: (206) 368-2419</td>
<td>Fax: (907) 562-5659</td>
</tr>
</tbody>
</table>

### CARE MANAGEMENT DEPARTMENT

#### Operational Staff:

**Grace Ingrim, RN, BSN, CCM**  
Director, Medicaid Services West  
(907) 562-2123, (877) 480-2123  
E-mail: gracei@qualishealth.org

**Jane Bloom, RN, CCM**  
Manager, Medicaid Services  
(907) 550-7612, (877) 562-2803  
E-mail: janeab@qualishealth.org

#### PROGRAM:

**All Review Programs**

#### Medical Affairs:

**Eric Wall, MD, MPH**  
Senior Medical Director  
(206) 288-2330  
E-mail: ericwa@qualishealth.org

#### PROGRAM:

**Physician Review**  
**Medical Affairs**

#### Administration:

**Cara Robinson, RN, BSN, CCM**  
Director, Medicaid Services  
(206) 288-2343  
E-mail: carar@qualishealth.org

**Deon Westmorland, RN, BSN, CCM**  
Contract Administrator  
(206) 288-2347  
E-mail: deonw@qualishealth.org

#### PROGRAM:

**All Review Programs**
State of Alaska Contact Information

Division of Health Care Services
Phone: (907) 334-2400
FAX: 907.561.1684

Mailing Address:
State of Alaska
Department of Health & Social Services
Division of Health Care Services
4501 Business Park Blvd.
Building “L” Suite 24
Anchorage, AK 99503-7167
Appendix D
List of Exhibits
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Appendix D
List of Exhibits

Exhibit 1 Pre-service Review Flow Chart
Exhibit 2 Concurrent Review Flow Chart
Exhibit 3 Expedited Appeal Process Flow Chart
Exhibit 4 Standard Appeal Process Flow Chart
Exhibit 5 Case Management Referral Process Flow Chart
Exhibit 6 Case Management Assessment Process Flow Chart
Exhibit 7 Case Management Workflow – Initial Assessment to Closure Flow Chart
Exhibit 8 Pre-service Review Request FAX Form
Exhibit 9 Inpatient Review Concept Template
Exhibit 10 Inpatient Review Worksheet
Exhibit 11 Concurrent Review Request Form
Exhibit 12 Physical Rehabilitation Review Worksheet for Pre-service Review
Exhibit 13 Physical Rehabilitation Review Worksheet for Concurrent Review
Exhibit 14 Qualis Health Retrospective Review Request Form
Exhibit 15 Case Management Referral Form
Exhibit 16 Certification Modification Request Form
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Initial Contact to Qualis Health

Basic Demographic Data Collected

Clinical information received and Medical/ Surgical Necessity meets Criteria/Qualis Health Policy

Non-certification Letter Sent
(after the attending is given the opportunity to discuss the case with the reviewing physician)

P/PCC = Physician/Practitioner Consultant

LOS = Length of Stay
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Exhibit 3

Expedited Appeal Process

1. Web, telephonic, fax or written request for expedited appeal received within two business days of receipt of initial denial

2. QH may request copies of chart notes or medical record from provider

3. Involved parties have 2 hours to submit more information

4. Information received within 2 hours
   - YES
   - NO

4a. If no additional information is received, the appeal is based on information available

5. QH sends medical records to P/PC licensed in appropriate specialty within one working day of receipt of medical records

6. QH sends medical records to P/PC licensed in appropriate specialty within one working day of receipt of medical records

Go to 7

7. P/PC upholds original determination
   - YES
   - NO

7. QH notifies by web or telephone and sends letters to attending physician, hospital, and patient within one working day confirming original determination with clinical rationale and information regarding Qualis Health’s standard appeal process

8. P/PC upholds original determination
   - YES
   - NO

8. QH notifies attending physician, hospital, and patient (and claims payer, as required) within one working day with authorization number and approved dates of service modifying original determination and includes clinical rationale for the services non-certified and information regarding Qualis Health’s standard appeal process

9. P/PC Reverses original determination, approves case
   - YES

9. QH notifies by web or telephone and sends letters to attending physician, hospital, and patient (and claims payer, as required) within one working day with authorization number and approved dates of service reversing original determination.

P/PC = Physician/Practitioner Consultant
Expedited Appeal = An appeal of non-certification in a case involving urgent care.
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Exhibit 4

1. Request for standard appeal received within 180 days of initial denial

2. Qualis Health informs other parties that request for appeal has been received and request clinical information to support appeal.

3. Involved parties have 7 days to submit more information.

4. Information received within 7 days

4a. If no additional information is received, the appeal is based on information available.

5. QH sends medical record and/or additional information to P/PC in appropriate specialty.

6. P/PC returns completed appeal review, with decision, to QH within 5 to 8 calendar days

6a. P/PC upholds original determination

YES

QH sends letters to attending physician, facility, and recipient confirming original determination with clinical rationale and information regarding next level appeal process.

NO

6b. P/PC modifies original determination

YES

QH sends letters to attending physician, facility, and patient modifying original determination, with clinical rationale, certified dates of service, and contractor's appeal process in the letter.

NO

6c. P/PC reverses original determination, approves case

YES

QH sends letters with certified dates of services reversing original determination.

P/PC = Physician/Practitioner Consultant

*Review completed and letters mailed within 30 days of receipt of request to perform standard appeal.
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Referral requests received from:
Utilization Management Providers
DHCS/Patient/Family Claims Payer or other

Case screened against Case Management (CM) criteria

Case meets criteria?

NO → Case not managed

YES → Case assigned to case manager

Proceed to Case Management Assessment Process (Exhibit 6)
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Case Management Assessment Process

Case assigned to case manager

Case manager makes contact with patient/family

Case manager reviews program with patient/family and requests verbal consent

---

Patient/family signs consent & release of information

YES

Case Manager sends client introduction packet*

NO

Case Manager changes status of case to not managed/closed status, no further interventions

---

Case Manager contacts provider and/or physician to obtain current status

Case Manager discusses status with client

Case Management goals/interventions identified?

YES

Case converted to active status

NO

Case status converted to not managed/closed

---

Assessment completed and a report sent to Alaska Medicaid within 30 days

*Introduction packet includes Release of Information, Patient Introduction, Overview of Services, and Patient Bill of Rights
CM Care Plan collaboratively developed, including:
- Short Term goals
- Long Term goals
- Timeframes for re-evaluation & follow up
- Resources to be utilized
- Collaborative approaches to be used

CM goals and interventions identified? NO

YES

Case remains open/active

Updated Care Plans, reports, supervisory review completed every 30-60 days and case staffing every quarter

NO

Future needs anticipated? NO

YES

Case to inactive status

Case staffing, supervisory review, updated care planning and reports completed every 3-6 months

Meets case closure criteria

Case closed, including:
- Closing letter to patient/family
- Discharge status
- Outcomes
- Final report
- Satisfaction survey
Pre–service Review Request FAX Form

DATE: ________________________________
ATTN.: ______________________________
FAX #: ______________________________ PHONE #: ______________________________

FROM: ______________________________
FAX #: ______________________________

NUMBER OF PAGES (INCLUDING COVER SHEET): __________
If there is problem with the receipt of this facsimile, please call. ______________________________ Thank you.

RECIPIENT/PATIENT NAME: ______________________________
RECIPIENT/PATIENT DATE OF BIRTH: ______________________________
COMPLETE RECIPIENT ADDRESS: ______________________________
MEDICAID NUMBER: ______________________________
REQUESTED ADMIT DATE: __________ DIAGNOSIS CODE(S) ______________________________
PROCEDURE DATE(S): ______________________________
DAYS REQUESTED: __________ PROCEDURE CODE(S) ______________________________

CONTINUED STAY REVIEW? Y ( ) IF SO, REFERENCE # ______________________________
NEW ADMIT? ( ) TRANSFER ( )

SETTING: □ INPATIENT □ OUTPATIENT □ PHYSICIAN OFFICE □ OUT OF STATE
□ NO N–URGENT □ URGENT

PHYSICIAN NAME: ______________________________ PHONE # ______________________________
FAX # ______________________________

FACILITY: ______________________________ PHONE # ______________________________
FAX # ______________________________

CLINICAL INFORMATION: ______________________________

This message is intended for the use of the individual entity to which it is transmitted and may contain information that is privileged, confidential and exempt from disclosure under applicable laws. If the reader of this communication is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original communication to us at the address below via U.S. Postal Service. We will reimburse you for the mailing costs.

P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133
Phone: (800) 783-9207

Alaska Review FAX (800) 826-3630
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**Qualis Health**

**Inpatient Review Concept Template:**
This is provided as a tool to help organize information that will help patients get medically necessary services at the right level of care and at the right time while meeting Qualis Health’s need for appropriate InterQual® documentation. Please consider the following as a ‘guide’, not a requirement or guarantee of payment for admission or for continued stay review.

<table>
<thead>
<tr>
<th><strong>Demographics:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient name, ID number</td>
</tr>
<tr>
<td>• Attending name, pager number and best time for a Qualis Health Medical Director to call if needed</td>
</tr>
<tr>
<td>• The day or dates under review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SI [Symptom Intensity]</strong> – How sick is the patient? This places the patient’s services in context with their clinical condition and is needed both for initial review and for concurrent review</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the main clinical issue?</td>
</tr>
<tr>
<td>• Abnormal vital signs?</td>
</tr>
<tr>
<td>• Pain present– where, what is cause?</td>
</tr>
<tr>
<td>• Neurological Status: alert to obtunded</td>
</tr>
<tr>
<td>• Brief description of diagnostic tests [especially if lab or x–rays are abnormal]</td>
</tr>
<tr>
<td>• Any consultations and evaluations or procedures?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IS [Intensity of Services]</strong> – What care is the patient receiving?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• IV medications and frequency</td>
</tr>
<tr>
<td>• Any IV PRN meds given for nausea, pain? How often each day?</td>
</tr>
<tr>
<td>• IV fluids/ TPN</td>
</tr>
<tr>
<td>• Blood or blood products [should have a HCT as a reason]</td>
</tr>
<tr>
<td>• Oxygen needed? FiO2 and route? ABGs done or O2 sats?</td>
</tr>
<tr>
<td>• Diet / Tube feeds/ gavage [what is infant’s weight]</td>
</tr>
<tr>
<td>• If patient is on a sliding scale, what were high/low glucose values? How many coverage units were given on each day [not the routine doses]?</td>
</tr>
<tr>
<td>• Wound management: describe wound and dressing/ debridement/ special issues</td>
</tr>
<tr>
<td>• Any other treatments or therapies?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>DS [Discharge Screens]</strong> – What is the long–term plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What is the expected destination after the hospitalization?</td>
</tr>
<tr>
<td>• What discharge planning activities are being done</td>
</tr>
<tr>
<td>• What care needs are there post–discharge? Educational needs?</td>
</tr>
<tr>
<td>• Are there significant psycho–social issues?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact</th>
<th>Number</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska Medicaid Pre–Service</td>
<td>800-783-9207 8</td>
<td>00-826-3630</td>
</tr>
<tr>
<td>Idaho Medicaid Pre–Service</td>
<td>800-783-9207 8</td>
<td>00-826-3836</td>
</tr>
<tr>
<td>L &amp; I Pre–Service</td>
<td>800-541-2894 8</td>
<td>77-665-0383</td>
</tr>
<tr>
<td></td>
<td></td>
<td>206-366-3378</td>
</tr>
<tr>
<td>WA Teamsters Pre–Service</td>
<td>877-372-7861</td>
<td>206-368-2765</td>
</tr>
<tr>
<td>Private Insurance Pre–Service</td>
<td>800-783-8606 2</td>
<td>06-368-2765</td>
</tr>
<tr>
<td>L&amp;I Physician Hotline</td>
<td>877–665–0382</td>
<td></td>
</tr>
<tr>
<td>Medicaid / Private Physician Hotline</td>
<td>877–292–2615</td>
<td></td>
</tr>
</tbody>
</table>
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Inpatient Review Worksheet

DATE: Patient Name: ___________________ ID #: ___________________
Attending name /contact info*/best time: ________________________________________
Admit Diagnosis/Code __________________ Procedure Code _______________________

Review covers dates from ___________ to ____________

What is the main reason the patient is in the hospital for this day/days? ____________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Please include a brief description of progress, diagnostic tests & results, consultations, evaluations:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

IV medications & frequency: & IV PRN meds [esp. pain] & # of times given per 24h
_____________________________________________________________________________
_____________________________________________________________________________

IV fluids/TPN/ lipids/ rates/bolus/ blood: __________________________________________
_____________________________________________________________________________

Respiratory status/treatment ____________________________________________________

Nutritional status/treatment ____________________________________________________

Insulin coverage/ values: ______________________________________________________

Wound mgmt issues/frequency: _________________________________________________

Other treatments:
____________________________________________________________________________
_____________________________________________________________________________

Brief description of Discharge Planning: expected destination/ care needs/ educational needs
_____________________________________________________________________________
_____________________________________________________________________________

In case the attending needs to be called by a Qualis Health Medical Director.
Please identify a pager # or office number, and best time to call.
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### Patient Information (Please print or type)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
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<td>Gender</td>
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<td>Patient DOB</td>
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<tr>
<td>Description of Injury</td>
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### Facility and Attending Physician Information (Please print or type)

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<tr>
<td>Facility Reviewer Name</td>
<td>Phone #</td>
</tr>
<tr>
<td>Attending Physician Name</td>
<td>Phone #</td>
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### Clinical Information (Please print or type)

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<td>Date Range of request</td>
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<td>Chart Notes Attached?</td>
<td>Number of Pages</td>
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<td>Yes ☐</td>
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<tr>
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<tr>
<td>Current Treatment Plan</td>
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<td>Contact Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
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<tr>
<td>Alaska Medicaid</td>
<td>800-783-9207 800-826-3630</td>
</tr>
<tr>
<td>Idaho Medicaid</td>
<td>800-783-9207 800-826-3836</td>
</tr>
<tr>
<td>L &amp; I</td>
<td>800-541-2894 877-665-0383</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>800-783-8606 877-810-9265</td>
</tr>
<tr>
<td>WSHIP</td>
<td>800-549-7549 866-891-0581</td>
</tr>
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</table>
Physical Rehabilitation Review Worksheet
For
Pre–service Review

Initial Call Date: ________________ Caller’s Name: ________________ Phone: ________________

Planned Rehabilitation Admission Date: ________________

Patient’s Name: ________________

Patient’s Address: ________________

Birth Date: ________________ Sex: ________________

Medicaid ID Number: ________________

Rehabilitation Facility: ________________ Location: ________________

Current Physician Name: ________________ Physician ID #: ________________ Phone #: ________________

Proposed Rehabilitation Physician: ________________ Physician ID #: ________________ Phone #: ________________

Phone: _____ Address: _____ City: ________________ State: ________________ Zip: ________________

ICD–9–CM Code(s): __________________________________________________________

and written description ______________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Relevant Surgery Codes: ______________________________________________________

_________________________________________________________________________

_________________________________________________________________________

**Severity of Illness**

What is the illness/injury/surgery or exacerbation that has occurred within the last 30 days? ________________

_________________________________________________________________________

What is the mobility, ADL or respiratory impairment requiring at least minimum assistance? ________________

_________________________________________________________________________
Severity of Illness (continued)

Is the patient clinically stable within the last 24 hours? Please provide the temperature, heart rate, respiratory rate and BP from the last 24 hours.

Is the patient able to tolerate the comprehensive rehabilitation program of 3 hours/day or longer of skilled therapy for 5 days or greater a week?

Is the patient able to follow visual/verbal commands?

Does the patient desire and able to actively participate?

Is the patient active in the community and home prior to admission with rehabilitation potential?

Is the patient fully participating in the therapeutic evaluation and interventions prior to transfer?

Is the admission a trial admission for 1 week or less?

Is the prospective assessment completed by a rehabilitation professional?

Is full participation/tolerance projected?

What therapies are indicated?

Is the treatment precluded in a lower level of care due to the clinical complexity?
Severity of Illness (continued)

Will the physician do an assessment/intervention 3 times/week or greater? ____________________

Is there specialized therapeutic skills/equipment required? If so, please identify? ____________________

Will the rehabilitation nursing services be available 24 hours/day? ____________________

Intensity of Service

Will The Progressive Therapy Program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

- ADLs
- Bed mobility/Transfers
- Home Lifestyle modifications
- Positioning/Splinting
- Pulmonary rehabilitation
- ROM/Stretching
- Speech language retraining
- Swallowing retraining
- Wheelchair mobility/Ambulation/Balance

If this is an admission trial of 1 week or less, the program will provide:

- At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy
- Full participation in evaluation/therapy
- Rehabilitation evaluations completed with in 2 days

Identify the new medical condition that decreases the patient’s participation in therapy for less than 3 hours/day for up to 3 days. ____________________

What medical/psychosocial management is required for this patient? ____________________
Patient’s Name: ________________________________

Program Coordination

What is the ongoing needs assessment/procurement? ________________________________

What instruction does the patient require? ________________________________

What is identified as discharge needs, barriers, patient support systems? ________________

Disposition Planned:
1. If Goals Achieved: ________________________________
2. If Goals Not Achieved: ________________________________

Physiatrist’s Plan of Care and Recommendation (if applicable):

______________________________

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This message is intended for the use of the individual entity to which it is transmitted and may contain information that is privileged, confidential and exempt from disclosure under applicable laws. If the reader of this communication is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original communication to us at the address below via U.S. Postal Service. We will reimburse you for the mailing costs.

P.O. Box 33400 10700 Meridian Avenue North, Suite 100 Seattle, WA 98133 Phone: (800) 783-9207 Alaska Review FAX (800) 826-3630
Physical Rehabilitation Review Worksheet
for
Concurrent Review

Call Date: ________________ Caller: ________________ Reference # ________________
Admit Date: ________________
Patient’s Name: ________________________________________________________________
Medicaid #: ________________________________________________________________
Rehabilitation Facility: __________________________________________________________
Phone #: ________________________________________________________________

New Procedures: ____________________________________________________________ Date: ____________

In general, has measurable improvement been documented weekly? Yes ☐ No ☐

Indicate: 1. Specific improvement in the following areas or lack of, and

________________________________________________________________________

________________________________________________________________________

2. Revision of goals if necessary

________________________________________________________________________

________________________________________________________________________

**Improvements: Comments:**

<table>
<thead>
<tr>
<th>Area</th>
<th>Y</th>
<th>N</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Function</td>
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</tr>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence, Bowels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence, Bladder</td>
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<td></td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Pain Management</td>
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<tr>
<td>Perceptual Motor Function</td>
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<tr>
<td>Self–Care Activities</td>
<td></td>
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</tbody>
</table>
Exhibit 13 (continued)

Patient's Name: __________________________________________

Intensity of Service

Will The Progressive Therapy Program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

- ADLs
- Bed mobility/Transfers
- Home Lifestyle modifications
- Positioning/Splinting
- Pulmonary rehabilitation
- ROM/Strengthening
- Speech language retraining
- Swallowing retraining
- Wheelchair mobility/Ambulation/Balance

If this is an admission trial of 1 week or less, the program will provide:

- At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy
- Full participation in evaluation/therapy
- Rehab evaluations completed within 2 days

Identify the new medical condition that decreases the patient's participation in therapy for less than 3 hours/day for up to 3 days: __________________________________________

What medical/psychosocial management is required for this patient? __________________________________________

Program Coordination

What is the ongoing needs assessment/procurement? __________________________________________

What instruction does the patient require? __________________________________________

What is identified as discharge needs, barriers, patient support systems, and patient capabilities? ________

__________________________________________

__________________________________________
Patient’s Name: ______________________________

Disposition Planned:
1. If Goals Achieved: ________________________
2. If Goals Not Achieved: ____________________

Physiatrist’s Plan of Care and Recommendation (if applicable):
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

Number of Days Requested: _________
Number of Days Approved: _____________
Approved Until: ________________________
Authorization #: ________________________
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# Retrospective Review Request Form

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Date of Birth</th>
<th>Insurance ID #</th>
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## Insurance Information:
- [ ] AK Medicaid
- [ ] ID Medicaid
- [ ] WA Labor & Industries
- [ ] Private

## FACILITY INFORMATION

<table>
<thead>
<tr>
<th>Facility</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Physician</th>
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</table>

<table>
<thead>
<tr>
<th>UR Contact Person</th>
<th>UR Phone #</th>
<th>Fax #</th>
</tr>
</thead>
</table>

## Request Reason (PLEASE CHECK ALL THAT APPLY):

- [ ] Exceeds LOS
- [ ] Pre–Service Review Late
- [ ] Other ____________________________
- [ ] Medicaid Patient (Eligible post admit date) eligible date ________________
- [ ] Medicaid Eligible (Eligible before admit date) eligible date ________________
- [ ] Concurrent Review Late
- [ ] Previous authorization # ____________________________

For lengths of stay **less than 15 days**, please submit the following information:

- [ ] UB 04
- [ ] DC Summary
- [ ] H & P
- [ ] Operative Report (if applicable)

For lengths of stay **15 days or greater** & ID Medicaid psych diagnosis for patients under age 21, **PLEASE SEND ENTIRE MEDICAL RECORD**

## Additional Information needed for

- Rehabilitation: Weekly Team Meeting Notes, Functional Status, Goals
- Adult Psychiatric/Chemical Dependency: MD and Multi–disciplinary Progress Notes, Medication Administration Record

## ADDITIONAL INFORMATION MAY BE REQUESTED

**Fax completed form to Qualis Health**

<table>
<thead>
<tr>
<th>AK Medicaid Patients: 800-826-3630</th>
<th>Mail medical record to Qualis Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID Medicaid Patients: 800-826-3836</td>
<td>Qualis Health 10700 Meridian Avenue North, Suite 100</td>
</tr>
<tr>
<td>WA Labor &amp; Industries Patients: 877-665-0383</td>
<td>PO Box 33400 Seattle, WA 98133-0400</td>
</tr>
<tr>
<td>Private Patients: 877-810-9265</td>
<td></td>
</tr>
</tbody>
</table>

## For Internal Use Only – Calls Made for Additional Information

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| From: | ________________ |
| RE: | ________________ |

| Patient Name | ____________________________ | Plan | ________________ |
| Patient SSN | ____________________________ | Date of Referral | ________________ |
| Address | ____________________________ | Contact | ____________________________ |
| City | ____________________________ | Phone | ____________________________ |
| Zip | ____________________________ | Phone | ____________________________ |
| Phone (W) | (H) | ____________________________ | Phone | ____________________________ |
| Subscriber Name | ____________________________ | Primary Diagnosis | ____________________________ |
| Subscriber Number | _______ - _______ - _______ | Secondary Diagnosis | ____________________________ |

| Current issues | ________________ |
| | ________________ |
| | ________________ |

| Primary Care Physician | ____________________________ |
| Phone | ____________________________ |

| Physician Specialist if applicable | ____________________________ |
| Specialty | ____________________________ | Phone | ____________________________ |

| Reason for referral | ________________ |
| | ________________ |
| | ________________ |
| | ________________ |

| Expectations | ________________ |
| | ________________ |
| | ________________ |
| | ________________ |

| Other | ________________ |
Certification Modification Request Form

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<tr>
<td>Recipient Name</td>
<td>FAX Number</td>
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<td>Facility</td>
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<tr>
<td>Reference #</td>
<td>Facility ID Number</td>
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<tr>
<td>Provider</td>
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Needed Corrections:

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<td>Certification # Used</td>
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<td>DX codes</td>
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<td>PX codes</td>
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<td>Recipient ID</td>
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</table>

Other Problems

FAX response to: Facility Provider Claims Payer

Mail response to: Facility Provider

Contact Person FAX Number

Signature/Date

For Qualis Health Use Only:

Describe changes made:

Check when completed in data system

Signature/Date

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Thank you.

P.O. Box 33400 10700 Meridian Avenue North, Suite 100 Seattle, WA 98133
Phone: (800) 783-9207
Alaska Review FAX (800) 826-3630
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