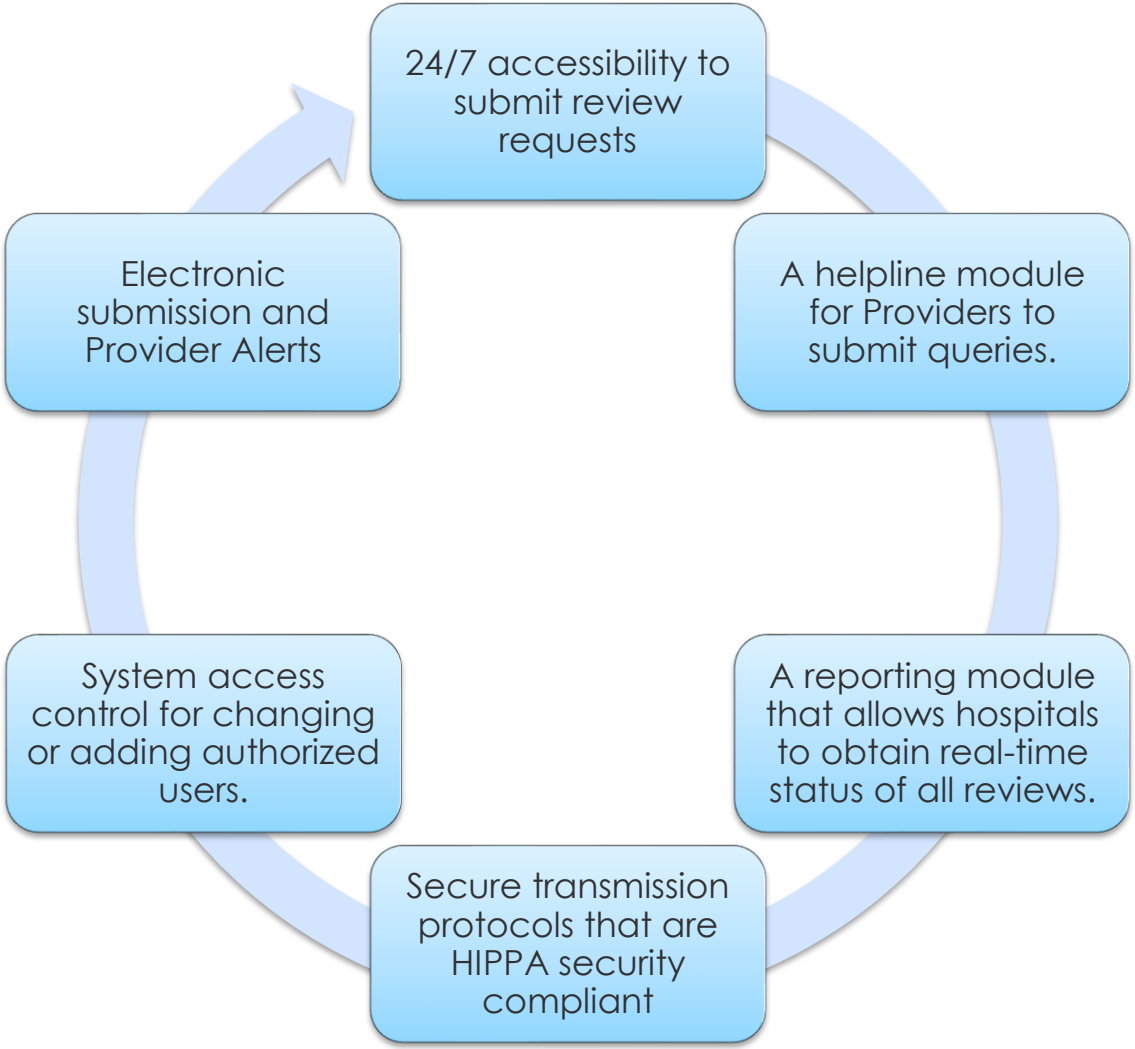
Inpatient Services

2020

Overview of eQsuite®



How to access eQsuite®

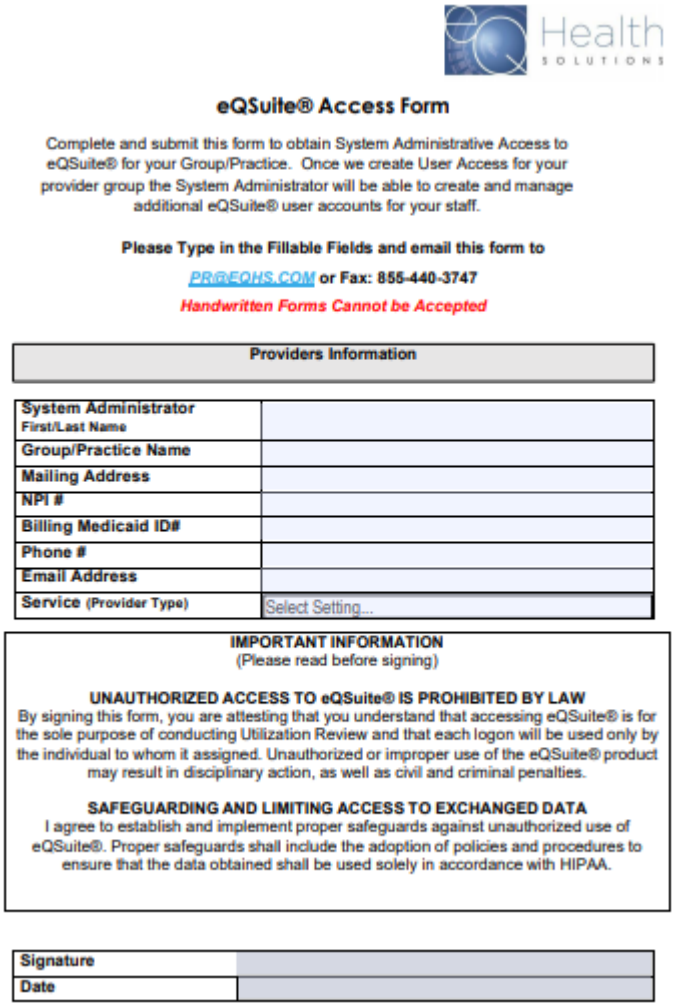
New Users:

You will need to complete and submit an access form.

(Once received and entered you will receive an email confirmation with your user name and password)

System Administrator:

- ✓ The person assigned will be responsible keeping all user accounts updated. *(Email address/phone numbers etc.)*
- ✓ You will have the ability to create additional User Accounts.
- ✓ Keeping all users informed of any updates or notifications sent from eQHealth.



Health SOLUTIONS

eQSuite® Access Form

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

Please Type in the Fillable Fields and email this form to

PR@EQHS.COM **or Fax: 855-440-3747**

Handwritten Forms Cannot be Accepted

Providers Information	
System Administrator First/Last Name	
Group/Practice Name	
Mailing Address	
NPI #	
Billing Medicaid ID#	
Phone #	
Email Address	
Service (Provider Type)	Select Setting...

IMPORTANT INFORMATION
(Please read before signing)

UNAUTHORIZED ACCESS TO eQSuite® IS PROHIBITED BY LAW
By signing this form, you are attesting that you understand that accessing eQSuite® is for the sole purpose of conducting Utilization Review and that each logon will be used only by the individual to whom it assigned. Unauthorized or improper use of the eQSuite® product may result in disciplinary action, as well as civil and criminal penalties.

SAFEGUARDING AND LIMITING ACCESS TO EXCHANGED DATA
I agree to establish and implement proper safeguards against unauthorized use of eQSuite®. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with HIPAA.

Signature	
Date	

Important Information

- ✓ All authorization requests should be submitted online via eQSuite.
- ✓ Check Medicaid eligibility prior to submitting your request.
- ✓ Authorization requests must be submitted with the date of Admission, not the date of eligibility.
- ✓ The provider will only receive payment for the days the recipient had valid coverage for the PA authorized date span.

FL Medicaid Inpatient Hospital Services Coverage Policy

2.0 Eligible Recipient 2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

Exempt from review

- **Death on the day of admission**
  FL Medicaid Provider Reimbursement Handbook, CMS-1500
- **Maternal addiction program**
  FL Medicaid Provider General Handbook (1-5)
- **Outpatient observation**
  FL Medicaid Inpatient Hospital Services Coverage Policy Bullet 4.2.3
- **Hospice related care**
  FL Medicaid Inpatient Hospital Services Coverage Policy-Bullet 5.2
- **Transplant procedures up to 1 year post transplant**
  FL Medicaid Provider Reimbursement Handbook, CMS-1500
- **Qualified Medicare Beneficiaries (QMB)**
  FL Medicaid Provider General Handbook (3-27)
- **Specified Low Income Medicare Beneficiaries (SLMB)**
  FL Medicaid Provider General Handbook (3-28)
- **Individuals who are inmates of public institutions on the day of admission (Unless there is documentation that states the inmate was released)**
  FL Medicaid Provider General Handbook (3-2)
- **Elective scheduled surgeries for recipients under 21 do NOT require prior authorization.**
  Exceptions: (Bariatric Surgery, Hysterectomy, and Elective C Sections)
  FL Medicaid Provider Reimbursement Handbook, CMS-1500

Review Completion Timeframes

Review Type	1st Level Review	2nd Level Review (Physician Reviewer)
Initial (Admission)	4 Hours	Within 1 business day of the receipt of the complete request
Continued Stay	4 Hours	Within 1 business day of the receipt of the complete request
Balanced Budget Act (BBA)	1 Business Day	Within 2 business days of the receipt of the complete request
Retrospective Review •Post Discharge •Undocumented Non Citizen •Medically Needy or Retroactive Medicaid Eligibility	20 Business days Note: ▪Review is performed when Medicaid eligibility is determined retroactively and after discharge ▪The review request must be submitted within 12 months of the FLMMIS date of determination	Within 20 business days of the receipt of the complete request

Review Status

Review Status Determinations

- PEND: Additional information is being requested
- 1st Level Review: The review is currently being reviewed
- 2nd Level Review: If medical necessity cannot be made at 1st level review gets referred to a physician reviewer
- Cancel: Duplicative Service or line items not entered correctly, No Medicaid eligibility, Untimely Submission

Pended Reviews

- Please make sure to review the pend completely. There may be more than one item that is being requested from the reviewer, failure to respond to the entire request will result in additional pend. This delays the review and delays the recipient getting service.

Reconsideration and Fair Hearing Rights

- Partial and full denials have reconsideration and Fair Hearing Rights. Recipients or their parent/legal guardian need to be made aware of this process. There are time limitations for the requests outlined in the denial letter.

Fee for Service-DRG

Important information regarding submitting your clinicals supporting documentation

- ✓ Provide supportive rationale for the day of the admission include presenting signs and symptoms and medication administration.

Examples:

- *If the patient is admitted with shortness of breath provide the O2 sat*
- *If the patient is admitted with chest pain, provide the troponin and EKG results*
- *If the patient is admitted for electrolyte imbalance, provide the lab values*

- ✓ Provide the patients previous medical history that is relevant to the admission. For surgical admissions clarify if the request is for a pre-op day or day of surgery, if its is for the pre op explain the medical necessity for the pre-op day
- ✓ If the patient is being converted from observation to inpatient, please provide the supportive rationale for the day the patient is converted to inpatient.
- ✓ If the patient is being transferred , please state clearly what service the patient is being transferred for that are not available at the current facility.

Services

- Medical/Surgical
- Acute Inpatient Psych
- Inpatient Rehab

Clinical Submission should include

- The 1st Inpatient day
- Clearly indicate the date of admission- Do **NOT** submit clinical for observation days
- The state of the recipients eligibility at the time of admission will apply to the entire stay.

Claim is paid

- DRG

Undocumented Non-Citizen

How to Improve your Undocumented Citizen Review Outcomes

Clinical Supporting documentation should include:

- ✓ Relevant past medical history; including the reason for admission to the hospital with focus on the emergent condition and all interventions delivered to relieve that emergent situation.
- ✓ Daily supporting documentation should address the need for continued inpatient treatment. Include, at minimum interventions performed and medication administration. Documentation in the record of when the health care team identifies stabilization of the emergent condition.

These reviews are for the consideration of the clinical support of a life threatening emergency requiring acute admission and the determination of dates covered is through the stabilization of that emergency.

Note: If an undocumented citizen receives Medicaid during the stay, the state of eligibility at the time of admission will apply the entire stay. A new case should not be submitted.

Services

- **Medical/Surgical**

Clinical Submission should include

- Daily clinicals for the entire length of stay

Claim paid as

- Per Diem
- Exception, Delivery Services- paid as DRG

BBA Eligible

- Prior Authorization review is required for adults age 21 and older who incur an emergency admission and have exhausted their 45-day inpatient Hospital benefit
- If you submit a reconsideration on a BBA request this does not change the DRG payment.
- The state of the recipients eligibility at the time of admission will apply to the entire stay.

Example: If a review is submitted with an admission date of March 1st and the stay crosses over the fiscal year you should **NOT** be entering a new review.
(Fiscal Year: July 1st-June 30th)

Services
- Medical/Surgical
- Acute IP Psych

Clinical submission should include
- Daily clinicals for the entire length of stay

Claim paid as:
- DRG

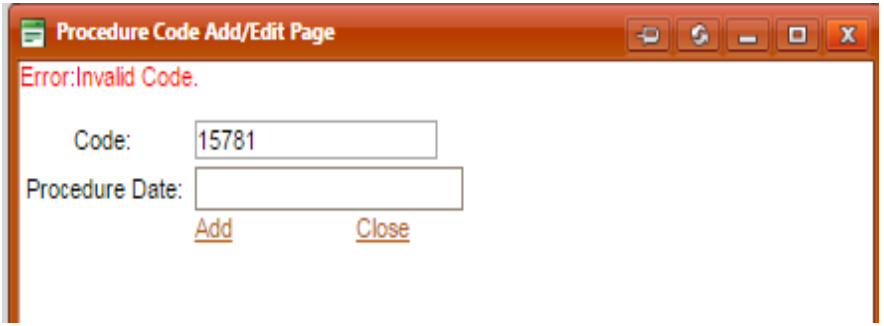
Other Services

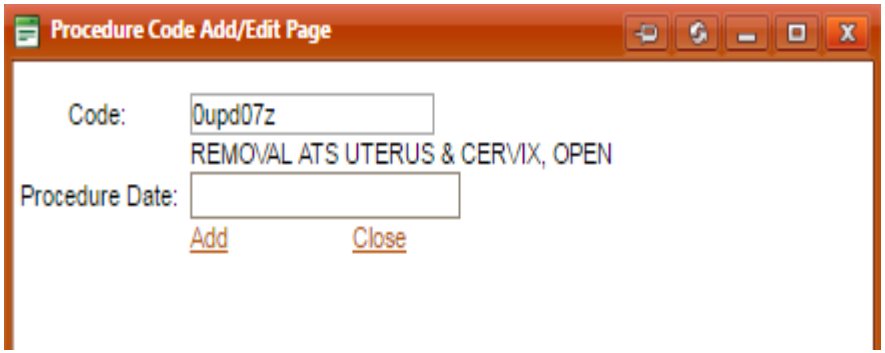
TB (Provided by a designated provider)	**SIPP** (Statewide Inpatient Psychiatric Program)	**Dialysis**
✓Clinicals should be submitted for the entire length stay ✓Per Diem	✓Clinicals should be submitted for the entire length of stay ✓Per Diem	Undocumented Non-Citizen: ✓Clinicals should be submitted for the entire length of stay ✓Per Diem Supporting Documentation: ✓If patient has history of End Stage Renal Disease or presents with Acute Renal Disease the supporting documentation should indicate the first date of dialysis.

CPT Codes vs ICD-10 PCS Codes

2019 ICD-10 PCS

- CMS Guidelines- ICD-10 PCS Codes (Procedure Coding System)should be entered in for Medicaid inpatient requests.
- Any attempts to enter a CPT Code on the Procedure Code Item tab for an Inpatient request will result in an "Error: Invalid Code" and no description of the code will appear.
- eQHealth cannot provide the code you should be using. You will need to research and choose the appropriate code for your request.





Resources to find the correct Procedure Code

1. You can contact the scheduling Hospital directly to obtain the correct Procedure Code (HIM, Health Information Management or Scheduling Dept)

2. You can reference the ICD 10 Data Website http://www.icd10data.com/ICD10PCS/Codes

3. You can reference the CMS Website https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html

Authorization/Billing

- Inpatient requests only receive 1 Prior Authorization number
- Both the Physician and the Hospital can bill using the same Prior Authorization number, separate requests should not be entered.
- FLMMIS does not compare CPT codes vs PCS codes on claims
- eQHealth determination does not guarantee Medicaid payment for services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program

LIVE DEMONSTRATION

eQHealth Resources