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# **Mississippi Medicaid – Advanced Imaging Services Provider Manual**

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**Introduction:** eQHealth Solutions’ Advanced Imaging Utilization Management Program includes prior authorization and retrospective review Advanced imaging services as denoted by Mississippi Division of Medicaid. A list of services requiring utilization review can be found at <http://ms.eqhs.org/>. Prior authorization for advanced imaging services by eQHealth Solutions applies to Mississippi Medicaid beneficiaries who are not enrolled in the Mississippi Coordinated Access Network (MSCAN), or Children’s Health Insurance Plan (CHIP). This manual should be used as a companion to the Mississippi Administrative Code and the Medicaid fee schedule.

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Section I – What you need to know before examining a  
Medicaid beneficiary:



**Did you check beneficiary eligibility?**

The plastic Medicaid card is not a guarantee of Medicaid eligibility. You must access the beneficiary's eligibility and service limit information through the eligibility verification options before submitting a prior authorization request to eQHealth Solutions.

You are responsible for verifying a Medicaid beneficiary's eligibility each time the beneficiary appears for service. You are also responsible for confirming the person presenting the card is the person to whom the card is issued.

You can verify eligibility by the Medicaid ID number or Social Security number of the beneficiary to access either of the following services:

- Website verification:
  - <https://www.ms-medicaid.com/msenvision/>
- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/Beneficiary Services Call Center at 1-800-884-3222
- Medicaid Eligibility Verification Services (MEVS) transaction using personal computer (PC) software or point of service (POS) swipe card verification device.

**Medicaid Coverage – Categories of Eligibility (COE)**

Authorization of Advanced Imaging services by eQHealth Solutions is applicable for Mississippi Medicaid beneficiaries in the following eligibility categories:

- Fee-for-service eligible beneficiaries.

Prior authorization by eQHealth is not required for:

- Beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN), or Children’s Health Insurance Plan (CHIP)
- Beneficiaries in COE 29, Family Planning Waiver
- Beneficiaries with no Medicaid coverage for the date of service
- Beneficiaries who are dually eligible for Medicare and Medicaid
- Dually coverage, by private insurance and Medicaid.

Please check eligibility at each visit.

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## Section II – Submitting your prior authorization request:

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### How to submit your request

Reviews are primarily submitted electronically using eQHealth's proprietary Web-based software, eQSuite®.

#### eQSuite's® Key Features Include:

- Secure HIPAA-compliant technology allows you to electronically record and transmit most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users.
- 24x7 access with easy to follow data entry screens.
- Rules-driven functionality and system edits which assist you by immediately alerting them to such things as situations for which review is not required.
- A reporting module that provides the real time status of all review requests.
- A HELPLINE module through which providers may submit questions about a specific PA request.

#### Minimal System Requirements

- Computer with Intel Pentium 4 or higher CPU and monitor
- Windows XP SP2 or higher
- 1 GB free hard drive space
- 512 MB memory
- Internet Explorer 8 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher
- Broadband internet connection

eQHealth will provide information explaining everything you need to know to access eQSuite®. To get started, you will designate a system administrator, and eQHealth will assign a user ID and password for him or her. The administrator does not need to be an information systems specialist; however, this person will be responsible for your organization/offices' user IDs and passwords. Managing system access is a user-friendly, non-technical process.

## Types of Review Requests

### New Service Request for dates of service after March, 1 2016

- Submit the PA request a minimum of **three (3) business days** prior to the planned service date

### Retrospective authorization request for dates of service on and after March 1, 2016

- Retrospective review is available for diagnostic imaging under one of two circumstances:
  - A medical emergent condition or situation as defined below:
    - The patient faces immediate risk of loss of life or limb,
    - Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or
    - In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to sever pain that cannot be adequately managed without the requested advanced imaging procedure.
  - Submit the authorization request within (3) three business days from the date of service. For extenuating circumstances contact eQHealth.

### Retroactive Medicaid eligibility authorization request for dates of service on and after March 1, 2016

- Retroactive Medicaid eligibility was issued to the beneficiary. MS Admin Code Title 23, Part 220 Radiology Services Rule 1.2.E.2 a -c
- For service performed on a beneficiary with retro-eligibility submit the review request as soon as eligibility is confirmed but no later than one year after eligibility is approved by DOM.

eQHealth completes requests for services as quickly as possible, but within specific timeframes. The timeframe depends on when the service is anticipated to occur (New Request/Admission review) or has already been provided. The request/review completion timeframe is measured from the date eQHealth receives your request

- Prior Authorization requests: 2 business days
- Retrospective review requests: 5 business days
- Retroactive eligibility review requests: 5 business days

eQSuite® guides you through the request submission process. However in this section we explain the prior authorization review process for Advanced Imaging services.

### Advanced Imaging Line Items

When providers submit PA requests, each CPT © code for which authorization is requested must be itemized. That is, each code must be entered in eQSuite® as a separate line item. For each item, the service “from” date is populated from anticipated or actual service date information you provide in the beginning, the thru date is calculated 60 days later. In other words, authorizations are given for a 60 day span of time to allow the service to be performed. The default number of units is one (1) and cannot be modified.

A special note regarding code 78499 Unlisted Cardiovascular Procedure; this code is manual priced by report. Provider needing authorization for this code should submit to eQHealth the details of the procedure to be performed, cost of the procedure, as well as the clinical information supporting the need for the procedure.



## Section III – What eQHealth looks for when reviewing your request

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### **The eQHealth Review Team, who we are:**

eQHealth is a multidisciplinary team. The eQHealth Medical Director oversees the review process. The requests submitted for review are processed by eQSuite®, Mississippi licensed registered nurses and physicians.

### **Automated Administrative Screening**

When the review request is entered in eQSuite® the system applies a series of edits to ensure authorization by eQHealth is required and that all Medicaid eligibility requirements, Administrative Codes and policies are satisfied. If there is an eligibility issue or the services are not subject to review, the system will inform and prompt the user to cancel the review.

### **Clinical Reviewer (1st Level) Screening of the Request**

When there are no review exclusions identified by eQSuite® the system routes the request to a first level reviewer who screens and reviews the request. The first level reviewer evaluates the entire request for compliance with Administrative Code that cannot be applied by the automated process and for compliance with supporting documentation requirements.

### **Screening for Compliance with Administrative Code**

If the first level reviewer identifies an issue with the request related to Medicaid requirements, a technical determination (TD) is rendered and your review will not proceed. The requesting provider is notified electronically through eQSuite®, and by a phone call. Since a technical determination is rendered for an administrative reason (not a clinical or medical necessity reason) it is not subject to reconsideration.

If all required information is not received with the request, the first level reviewer “pends” the request. You will be notified electronically and by phone call. The information must be received within three (3) business day. If it is not received within the specified time frame the review request is suspended and you will be notified electronically. If the information is submitted at a later date eQHealth will re-open the review and the review will be performed for services from the date the information is received. eQHealth cannot backdate the request.

## **Clinical Information: Screening, Pended and Suspended Requests**

### **Clinical Information Screening**

Before performing the medical necessity review, the first level reviewer screens the submitted clinical information for completeness. When additional clinical information is required or when the available information requires clarification, the first level reviewer pends the review request and specifies the information or clarification needed.

### **Pended and Suspended Review Requests**

When the clinical reviewer pends a review request:

- You will receive a phone call and you can access the review record to determine what additional information is needed.
- The requested information must be submitted within three (3) business day for admission reviews and ten (10) business days for retrospective reviews.
- If eQHealth does not receive the information within three (3) business day for an admission review, and ten (10) business days for a retrospective review or retroactive eligibility review from the date of notification, the review request is suspended and no further review processing occurs until the additional information requested has been received. When a request is suspended, you are notified electronically and by phone, the request is suspended. If the information is submitted at a later date, eQHealth re-opens the request and reviews the services beginning from the date the complete information was received. eQHealth cannot backdate the request.

### **First Level Medical Necessity Review Process**

When all information has been submitted and the clinical information screening is completed, the first level reviewer performs the medical necessity review. When performing the review, the first level reviewer evaluates all clinical information recorded in eQSuite® and evaluates all submitted information.

### **National Guidelines for Advanced Imaging services:**

eQHealth Solutions uses DOM approved National Clinical Guidelines (such as American College of Radiology Appropriateness Criteria) as a tool when making clinical determinations concerning the medical necessity of care. These guidelines are available at <http://ms.eqhs.org>.

### **Approvals**

First level reviewers apply Medicaid approved clinical guidelines to determine whether the services are medically necessary or otherwise allowable under Medicaid policy. If the criteria are satisfied, the clinical reviewer renders an approval determination for each line item, for the number of units requested and for the requested time frame or policy maximum.

### **Approval Notifications**

Approval notifications are generated for all services determined to be medically necessary.

- Electronic notifications are generated to the rendering practitioner/provider.
  - When the determination is rendered, the requesting provider's secure web-based provider status report is updated. The provider may access the report to see the determination.
  - Within one (1) business day of the determination eQHealth posts a provider notification letter. The notification specifies the authorized service(s), the number of units, the authorization period, and the Treatment Authorization Number (TAN). You may access the notification by logging onto eQSuite®. The notifications may be downloaded and printed.
  - eQHealth transmits the Treatment Authorization Number (TAN) to the Medicaid fiscal agent.

### **Referral to a Second Level Reviewer (SLR)**

First level reviewers may not render an adverse determination; any requests which they cannot approve are referred to a SLR. When the first level reviewer refers a review request to a SLR the requesting provider's Web-based status report is updated and displays the referral status.

### **Second Level (Physician) Review Process**

The SLR uses clinical experience, knowledge of generally accepted professional standards of care and judgment.

## Approval Determinations and Pended Reviews

For each service the first level reviewer was unable to approve, the SLR determines the medical necessity of the service and the number of units and service duration requested.

- *Approval on the basis of available information:* When the available information substantiates the medical necessity of the service(s), units and service duration, the SLR approves them as requested and the review is completed. Notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.
- *You may receive a “pend” if additional information is required:* If a SLR is not able to approve the service(s) on the basis of the available information, the SLR may attempt to speak with the treating practitioner to obtain additional or clarifying information. If the treating practitioner is not available when the SLR calls, the SLR may issue a pend determination at that time. Any information obtained telephonically or via pend is documented in the review record. If the SLR is able to authorize the service(s) on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete and notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.
- *SLR pended review requests.* You will receive an electronic notification of the pended review.
  - The information must be provided within three (3) business days.
  - If the requested information is not received within three (3) business days, the SLR renders a determination on the basis of the information that is available.

## Adverse Determinations

Only a SLR may render an adverse determination. As noted in the preceding section, prior to rendering an adverse determination the SLR may attempt to discuss the request with the treating practitioner. There are two types of adverse determinations: denial and partial denial.

### **Denial**

The SLR may render a (full) medical necessity denial of one or more line items.

- You will receive immediate electronic notification, via the eQSuite® review status report, of the denial. eQHealth will also phone with the denial decision.
- Within one (1) business day of the determination, the final written notification of the denial is posted electronically for you in eQSuite®. The notification may be downloaded and printed.
- Written denial notifications also are mailed to you and to the beneficiary or the beneficiary's parent or legal guardian/caretaker.
- The written notification includes information about your and the beneficiary's right to a reconsideration of the adverse determination.
- The beneficiary's notification also includes information about his/her right to request an appeal.

### **Partial Denial**

The SLR also may render a partial denial for the services. When a partial denial is rendered, some of the services are approved and some are denied.

Partial Denial Notifications:

- Notifications are issued to the parties as described in the preceding section, "Denial".
- For the services that are approved, the approval information is provided to the fiscal agent. The provider's eQSuite® status report and the final notification are updated with the TAN as previously described for approval determinations.

### **Reconsideration Reviews**

You, the beneficiary, or parent/guardian/caretaker may request a reconsideration of an adverse determination. Adverse determination notices contain instructions for requesting reconsideration: The reconsideration must be requested within 30 calendar days of the date of the denial notification. Additional information may be found in our

[Reconsideration Manual](#).

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## Section IV – IF YOU NEED INFORMATION OR ASSISTANCE

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We offer a variety of ways for you to obtain information or assistance you need when submitting prior authorization (PA or review) requests. In the following sections we identify, by topic or type of assistance needed, useful resources.

### **Questions about the Advanced Imaging Services Utilization Management Program**

For questions or information, the following resources are available:

- Resources available on our Web site: <http://ms.eqhs.org>:
  - eQHealth Advanced Imaging Services Provider Manual.
  - Training presentations: Copies of training and education presentations are available under the “Advanced Imaging” tab.
- eQHealth’s HELPLINE Toll free number 1-866-740-2221.

### **Questions about Using our Web-based Review System**

eQSuite® is our proprietary Web-based review system. It is used to submit PA requests for Advanced Imaging services. Questions about using eQSuite® should be submitted to the Helpline listings below..

### **Submitting Prior Authorization Requests by Means Other than Web**

If you do not use computers in your day-to-day operations, please contact eQHealth’s HELPLINE Toll free number 1-866-740-2221.

#### **Fax, Phone, and Mail PA Requests**

Provider who are unable to use eQSuite® can submit PA request via fax, phone or mail. Providers submitting fax request must use the PA request form located on our website <http://ms.eqhs.org>, complete the form and fax with physician’s order for service to 888-204-0377 toll free.

Providers submitting phone request can do so by calling 888-204-0502 toll free. The Advanced Imaging precert line is available 7:00AM – 6:00PM Central Time, Monday through Friday except holidays.

Providers can also mail PA requests to eQHealth. Providers submitting PA request by mail must use the PA request form located on our website <http://ms.eqhs.org>, complete the form and mail with physician’s order for service to: eQHealth Solutions 460 Briarwood, Ste 300, Jackson MS 39206



### **How to submit documentation when needed or requested**

To submit documentation to an existing request created in eQSuite® there are two methods you can follow:

- Upload and directly link the information to the eQSuite® review record.
- Download eQHealth's fax cover sheet(s) and submit the information using our 24 x 7 accessible toll-free fax number: 1-888-204-0377.

If you choose to fax the documentation, we provide downloadable special fax cover sheets. Each fax cover sheet includes a bar code that is unique to the specific review and for the type of required information. The review-fax cover sheet is available for download and printing as soon as the review request is completely entered in eQSuite® and submitted for review.

***DO NOT REUSE OR COPY BAR CODED FAX COVER SHEET(S) – THEY ARE SPECIFIC TO THE REVIEW TYPE FOR A PARTICULAR BENEFICIARY AND ARE SPECIFIC TO THE TYPE OF DOCUMENT.***

### **Checking the Status of a PA Request or Submitting an Inquiry about a Request**

To determine the status of a previously submitted PA request, use your secure eQSuite® login and check the information in your review status report. If you have additional questions about a previously submitted PA request, submit an inquiry using eQSuite's® HELPLINE module. Both options are available 24 hours a day. Although using eQSuite® is the most efficient way to obtain information about PA requests, you also may call our HELPLINE Toll free number 1-866-740-2221.

#### **eQHealth Solutions HELPLINE**

For general inquiries, or questions that cannot be addressed through eQSuite® or if you have a complaint, or a compliment, contact our HELPLINE Toll free number 1-866-740-2221. Our Helpline is available 8:00AM – 5:00PM Central Time, Monday through Friday except holidays. If you call during non-business hours, you have the option of leaving a message.

The eQHealth Helpline is also used to request changes to TANs issued by eQHealth. When submitting the change request please provide the following information:

1. Review ID, or
2. Bene ID, or
3. TAN, and
4. The exact revision being requested

If you have a complaint or compliment and would prefer to write to us, there are two options. Fax the information to our toll free Quality Concerns fax number: 1-888-204-0221 or mail the information to:

eQHealth Solutions- Mississippi Division  
Attention: Quality Concerns  
460 Briarwood Drive, Suite #300  
Jackson, MS 39206



## SECTION V - DEFINITIONS

Term	Definition
Administrative Appeal	If the reconsideration outcome was to uphold the denial and there is a disagreement with this decision, the beneficiary/legal representative may request an administrative appeal from the Division of Medicaid.
New Service/ Admission Review	The review performed by eQHealth when a new or existing patient's information is entered into the eQHealth web portal for the first time or is new to the precertification process. Admission Review is interchangeable with Precertification Review.
Bar Coded Fax Coversheet	Web utility option that allows the provider to print a specialized cover sheet encrypted with bar code technology that links required documents directly to a specific review. The coversheet is designed for one use and may not be altered in any way.
Denial	Occurs when requested services are not approved. Only a SLR can clinically deny a request.
Errors or Error Message	An eQSuites® message indicating the request is incorrect and can't be submitted, (i.e. submitting a prior authorization request for a MSCAN enrolled beneficiary will cause an error and is displayed as such.)
First Level Reviewers	<p>eQHealth first level reviewers:</p> <ul style="list-style-type: none"> <li>• Apply DOM policy.</li> <li>• Apply DOM approved medical necessity clinical guidelines.</li> <li>• Request additional information.</li> <li>• Refer requests that cannot be approved for dentist review and determination.</li> <li>• Authorize care.</li> </ul>

<p>Guidelines (clinical)</p>	<p>The U.S. Dept. of Health and Human Services’ states that clinical guidelines “...define the role of specific Advanced and treatment modalities in the diagnosis and management of patients”. The purpose of guidelines is to support health care decision-making by “describing a range of generally accepted [treatment] approaches...”</p> <p>In contrast with strict criteria and prescriptive protocols, guidelines provide recommendations for management of particular diseases or conditions. When referencing guidelines, emphasis is placed on the importance of exercising sound, situation-specific clinical judgment. Recommendations contained in guidelines are based on findings that certain Advanced or therapeutic practices have been found “to meet the needs of most patients in most circumstances”, [but clinical]</p> <p>“...judgment...remains paramount [in developing] treatment plans that are tailored to the specific needs and circumstances of the patient.” (NHLBI)</p> <p>Compare with “Criteria (clinical)”</p>
<p>International Classification of Diseases coding system</p>	<p>“ICD-10-CM Diagnosis and Procedure Codes” means the International Classification of Diseases, 10th Revision, and Clinical Modification, which is a method of classifying written descriptions of diseases, injuries, conditions, and procedures using alphabetic and numeric designations or codes.</p>
<p>National Provider Identifier (NPI)</p>	<p>HIPAA Administrative Simplification Standards. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses use the NPI’s in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-digit number.</p>

Pend	Refers to the process of placing a review request on hold until additional information has been received. eQHealth will notify the provider of the information needed along with a time frame for submission
Prior Authorization	Process for receiving approval for services.
Quality Improvement Organization (QIO)	<p>A federally designated organization as set forth in Section 1152 of the Social Security Act and 42 CFR Part 476. (QIOs were formerly called Peer Review Organizations [PROs].) They are firms that operate under the federal mandate to provide quality and cost-management services for the national Medicare Program and for states' Medicaid programs.</p> <p>The Center for Medicare and Medicaid Services (CMS) oversees the national Medicare QIO Program, and it requires that states contract with QIOs to assist them in managing the cost and quality of health care services provided to Medicaid recipients. By law, the mission of the federal QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to recipients. CMS reports that "Throughout its history, the Program has been instrumental in advancing national efforts to motivate providers in improving quality, and in measuring and improving outcomes of quality."</p>
Reconsideration	Following a clinical denial either the beneficiary/legal representative, service provider and/or attending physician can request reconsideration or "another look" by an eQHealth SLR, (different from the initial SLR) to review the request and any additional information submitted.

<p>Second Level Reviewers</p>	<p>eQHealth second level reviewers (SLR):</p> <ul style="list-style-type: none"> <li>• Make certification, denial or reconsideration determinations. That decision is:             <ul style="list-style-type: none"> <li>○ Based on documentation that supports prognosis and medical appropriateness of setting.</li> <li>○ Patient-centered and takes into consideration the unique factors associated with each patient care episode.</li> <li>○ Sensitive to the local healthcare delivery system infrastructure.</li> <li>○ Based on his or her clinical experience, judgment and accepted standards of healthcare.</li> </ul> </li> <li>• Request additional information.</li> <li>• Clinically deny certification</li> </ul> <p><b><i>Only a SLR can clinically deny a request.</i></b></p> <p>The second level reviewer may contact the ordering physician or vision service provider to obtain additional information when the documentation submitted does not clearly support medical necessity.</p>
<p>Supporting documentation</p>	<p>Supporting documentation is particular documentation required at the time of an authorization request for particular services.</p> <p>The nature of the required documentation varies according to the type of service and may vary according to the type of authorization request.</p>

Suspended review	<p>The status of a review request when a provider is notified that additional clinical information is needed to complete a review, but the provider does not submit the requested information within the required timeframe.</p> <p>A suspended review is a cancellation of the provider’s review request. If the requested information is submitted at a later date, the review request is unsuspending and review is performed. (Also see “Pend (or pended) review” and “Unsuspending review”.)</p>
Treatment Authorization Number (TAN)	<p>The acronym for “Treatment Authorization Number” is the number issued by eQHealth following the review approval process.</p>
Upload	<p>Web utility option that allows required documents in a .tif, .jpeg, or pdf files to be directly linked from a computer to a specific review.</p>
Unsuspending review	<p>The status of a review request when a provider submits all additional clinical information that was needed to complete a review. When all required information is submitted, eQHealth “unsuspends” the review request and completes the review. (Also see “Suspended review” and “Pend (or pended) review.”)</p>

## SECTION VI – ADVANCED IMAGING REVIEW WORKFLOW

