Mississippi Medicaid – Inpatient Services Provider Manual

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Introduction

eQHealth Solutions (eQHealth) is the Utilization Management and Quality Improvement Organization contracted to perform precertification for inpatient acute care services rendered to Mississippi Medicaid beneficiaries. The purpose of this manual is to assist providers in successfully navigating through eQHealth's review requirements and processes.

Getting Started - Helpful Tips

Before submitting any request to eQHealth, providers must access the beneficiary's eligibility through the eligibility verification channels that are provided. The provider is responsible for verifying a Medicaid beneficiary's eligibility each time the beneficiary appears for service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. Providers can receive information such as verification of client eligibility, other health insurance, and benefits remaining using the Medicaid ID number or social security number. Providers can verify eligibility by using any of the following services:

- Website verification at https://msmedicaid.acs-inc.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.

Providers must read and be familiar with DOM's policies and procedures located at http://www.medicaid.ms.gov/providers/administrative-code/
Requests for precertification should be submitted to eQHealth following:

- Identification of the need for inpatient level of care by a physician.
- Receipt of an order for inpatient admission.
- Discussion between the provider and attending physician regarding the need for services and the anticipated length of stay.

Information You Need to Know

The majority of inpatient providers submit review requests and receive eQHealth certification responses via eQSuite®, our HIPAA secure Web-based system provides 24 hour a day 7 days a week access to real-time electronic submission of:

- Review requests.
- Additional information for specific reviews when requested by eQHealth.
- Reports of maternity admissions for delivery.
- Helpline inquiries.

If you do not have a eQHealth Web portal user name and password, contact eQHealth at education@eqhs.org or by phone at 1-866-740-2221 to request enrollment and training.

In addition to Internet access, minimum computer specifications are:

- PC 1GHz+ processor, 512 MB+ RAM, 500MB of free space.
- Super VGA (1024x768) or higher resolution video card and monitor.
- Broadband internet connection with a speed of at least 512Kbps.
- Internet Explorer Version 8, Mozilla Firefox, or Google Chrome.

In the event an inpatient provider cannot submit via eQSuite®, eQHealth has dedicated phone and fax numbers to assist with certification needs. When submitting review request by fax or mail the required forms can be downloaded from our web site at ms.eqhs.org. The table below lists fax and phone numbers and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Inpatient Acute Care Admission, Continued Stay, Retrospective Short Stay Review Request Submission	Used by providers to submit review request and additional information requested by eQHealth.	**Web reviews:** https://mswebapps.eqhs.org/webportal/Login.aspx Fax and Web: 24 hours/day, 7days/week. Fax: 1-888-204-0504 Phone: 8:00 a.m. – 5:00 p.m. (business days) Phone: 1-888-204-0502
Retrospective Review Requests Submission	Used by providers to submit retrospective review requests.	Fax: 1-888-204-0504
Helpline	Used by providers for questions regarding the certification process and to obtain assistance.	Providers using the eQHealth Web Portal have 24/7 capability to submit Helpline request via the Online Helpline function found on the top ribbon menu. After hour submissions will be responded to on the following business day. Toll Free: 1-866-740-2221 Hours of availability: 8:00 a.m. – 5:00 p.m. (business days)
Hot Line	Number to use to report quality concerns and/or complaints.	Hours of availability: 8:00 a.m. – 5:00 p.m. (business days) Toll Free: 1-888-204-0221

Inpatient Review Exclusions

Medicaid policy exempts certain services from eQHealth review. Providers should not submit reviews for these situations. The table below outlines the reasons for review exclusion:

Reason	Description
No Medicaid Eligibility	No eQHealth review is required if the beneficiary does not have current Medicaid eligibility. If the patient has applied for Medicaid and the eligibility determination is pending, eQHealth cannot perform review. Once eligibility has been determined, eQHealth performs review based on the eligibility begin date.
Beneficiary enrolled in MSCAN	Effective 12/1/15, eQHealth will not perform review of admissions for beneficiaries enrolled in the coordinated care plan MSCAN. Providers should coordinate these services with the beneficiary's plan.
Medicare Eligibility	No eQHealth review is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization timeframe and the Medicare benefits are not exhausted.
Geropsychiatric	No eQHealth review is required if the beneficiary is admitted to a geropsyhciatric unit.
Family Planning Waiver	No eQHealth review is required if the beneficiary's Medicaid eligibility is only for the family planning waiver.
Outpatient Observation Admissions	No eQHealth review is required if the beneficiary is admitted to outpatient observation status or emergency department or other outpatient services without an inpatient admission.
Newborn Birth Admission	No eQHealth review is required for the birth admission of a baby born to Medicaid eligible mother **IF** • The baby is hospitalized for 5 days or less. **and** • The baby is discharged to custody of the Medicaid eligible mother. • **OR** The mother is enrolled in MSCAN

Note:

The following applies to all beneficiaries:

Providers who participate with Mississippi Medicaid are required by law to determine if a beneficiary is covered by a third party source, including Medicare.

Medicare A is the primary coverage for dual eligible beneficiaries, when combined with a Medicaid category of eligibility that has inpatient acute care as a service option.

Medicare A or B coverage, or any other third party insurance must follow precertification rules for Medicaid if pursuing Medicaid reimbursement for inpatient acute services.

Certification Review Process

Applicable review types, request submission timeframes, required documentation and submission methods are displayed in the following table.

REQUEST FOR CERTIFICATION REVIEW

Condition(s)	Description	Review Type	Request must be submitted	Required Documentation	Available Submission Methods			
					Web	Phone	Fax	Mail
Planned or elective admission and the beneficiary has not been admitted to the hospital.	Precertification of non-emergency admission; prior to admission.	Admission	No later than three business days prior to the planned date of admission.	• Enter information required by eQSuite. • eQHealth Admission Certification Request Form.	X	X	X	X
The beneficiary's admission was not planned or elective and the beneficiary has not been discharged.	Urgent/Emergent admission; post-admission.	Admission	On eQHealth's next business day	• Enter information required by eQSuite. • eQHealth Admission Certification Request Form.	X	X	X	X
The patient was admitted on a holiday and has not been discharged.	Holiday admission; beneficiary remains in hospital.	Admission	On eQHealth's next business day.	• Enter information required by eQSuite. • eQHealth Admission Certification Request Form.	X	X	X	X
The beneficiary was admitted on a weekend (Friday, Saturday, or Sunday) and has not been	Weekend admission; beneficiary remains in hospital.	Admission	On Monday.	• Enter information required by eQSuite. • eQHealth	X	X	X	X

Condition(s)	Description	Review Type	Request must be submitted	Required Documentation	Available Submission Methods			
					Web	Phone	Fax	Mail
discharged.				Admission Certification Request Form.				
The patient was admitted and discharged over the weekend (Admitted Friday afternoon and discharged by Sunday) and certification was not obtained.	Weekend hospitalization; beneficiary discharged.	Admission	By the first Friday following discharge.	• Enter information required by eQSuite. • eQHealth Admission Certification Request Form.	X	X	X	X
The beneficiary's admission was previously certified and the beneficiary remains hospitalized.	Additional inpatient days of care are desired; beneficiary remains in hospital.	Continued Stay	On or before the next review point, i.e., the last day certified.	• Enter information required by eQSuite • eQHealth Continued Stay Request Form	X	X	X	X
The beneficiary's admission was certified and the beneficiary was discharged.	Additional inpatient days of care require certification; beneficiary discharged.	Continued Stay	As soon as condition is identified. Certification must be obtained within one year of service dates.	• Enter information required by eQSuite. • eQHealth Continued Stay Request Form.	X	X	X	X

Condition(s)	Description	Review Type	Request must be submitted	Required Documentation	Available Submission Methods			
					Web	Phone	Fax	Mail
The beneficiary's admission was not certified and the beneficiary was discharged, **and** the length of stay was 19 days or less. Admissions and discharges over a weekend period should follow Weekend rules on page 5 above.	The length of stay was 19 days or less and a weekend admission and discharge did not occur.	Retrospective	As soon as condition is identified. Certification must be obtained within one year of service dates.	• Enter information required by eQSuite. • eQHealth Continued Stay Request Form.	X	X		
• DOM provides retroactive Medicaid eligibility for a beneficiary that was not eligible for Medicaid benefits at the time of hospitalization. • The beneficiary was hospitalized and discharged and certification was not obtained while the beneficiary was hospitalized.	The patient was admitted and discharged and certification was not obtained **and** the patient was not admitted and discharged over a weekend **and** the length of stay is greater than 19 days.	Retrospective due to Retroactive eligibility	As soon as condition is identified. Certification must be obtained within one year of retroactive Medicaid eligibility determination or within one year of service dates if beneficiary was Medicaid eligible during hospitalization and the claim was filed with the fiscal agent in a timely manner.	• Completed eQHealth Retrospective Request Form. • Copy of the complete medical record.			X	X

Non-Compliance with Submission Timeframes

eQHealth monitors and tracks the number of times a facility requests late certification either for admission, continued stay or retrospective review. On a quarterly basis, profiles are generated that identify the number of times a provider's request is non-compliant with submission timeframes. Late requests for certification are considered non-compliant in the following instances:

- The patient was eligible for Medicaid benefits at the time of admission, but precertification review was not requested.
- The admission was neither urgent nor emergent based on the clinical documentation submitted for certification.
- Continued stay review was not submitted on or prior to the last day certified (the next review point).

An example of an urgent admission is as follows: The beneficiary was seen by the physician on the day of admission and the physician identified an urgent problem that required immediate inpatient intervention to prevent an emergency condition.

A medical/surgical emergent admission is defined as: The admission to an inpatient hospital setting results from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could result in:

- permanently placing the beneficiary's health in jeopardy
- serious impairment to bodily function, or
- serious and permanent dysfunction of any bodily organ or part, or other serious medical consequence.

An emergency psychiatric admission is defined as: The admission to an inpatient hospital setting resulting from mental illness when the beneficiary's condition is such that he/she requires twenty-four (24) hour per day supervision in a secure setting and with presenting symptoms of such severity that the absence of immediate intervention could reasonably result in:

- permanently placing the beneficiary's mental health in jeopardy
- a serious threat to the physical welfare of the beneficiary and/or others, or
- serious and permanent mental dysfunction or other serious medical or psychiatric consequence.

The acute symptoms must be of such severity as to cause a person to seek medical or psychiatric assistance regardless of the hour of the day or night.

Processing of Review Requests

eQSuite® is the most efficient method by which certification is obtained. Upon submission of the review request DOM approved automated rules-based algorithms processes the request.

If the clinical documentation supplied	Then	Or
Meets the rules-based algorithm for medical necessity and length of stay assignment	• The length of stay (next review point) will be assigned. • eQHealth's system will generate the treatment authorization number (TAN) • Written and/or verbal notification is provided.	The review request is routed to a first level reviewer.

Telephonic review is the second most efficient request method because review is submitted directly to a first level reviewer. Faxed and mailed requests for certification review are processed by eQHealth intake staff. The intake staff is experienced and works collaboratively with clinical staff to provide quality services to our customers. eQHealth has a diverse group of professionals that assist at various stages of the review process. These highly qualified professionals make certification review determinations; however, only eQHealth's second level reviewers (physicians) may deny a request for services. The following table describes staff functions.

Staff	Functions
Non-Clinical Support Staff (Intake Staff)	• Screen requests for completeness. May request additional non-clinical information. • Perform verbal notification of review determination, as appropriate. • Support all review functions.
First Level reviewers (FLR)	• Apply DOM policy. • Apply DOM approved medical necessity clinical guidelines. • Apply quality of care triggers and screens. • May request additional information. • Approve services based on policy and criteria. • Refer requests that cannot be approved to a physician.

Staff	Functions

Second Level Reviewers (SLR) (Physicians)	• Make certification, denial or reconsideration determinations. The determination is:
	  ○ Based on documentation that supports medical necessity and appropriateness of setting. *
	  ○ Patient-centered and takes into consideration the unique factors associated with each patient care episode.
	  ○ Sensitive to the local healthcare delivery system infrastructure.
	  ○ Based on his or her clinical experience, judgment and generally accepted standards of healthcare.
	• May request additional information.
	• Only physicians may clinically deny a request.
	
	*The physician reviewer may request additional information and attempts to contact the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.
	
	Note: See the *Reconsideration Process* section of this manual for information on the reconsideration process.

Pending Reviews for Additional Information

There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with corresponding timeframes for the submission of the requested information by review type. If the requested information is not submitted by the due date, eQHealth suspends review of the request.

If the review cannot proceed because ...	**Then**	**Review Type**	**Timeframe for submission**
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.	Precertification, Planned or Elective Admission	Three business days.
		Admission	One business day.
		Continued Stay	One business day.
		Continued Stay (Beneficiary discharged)	Ten business days.
		*Retro Short Stay	One business day.
		Retrospective	Ten business days.

Notification of Review Outcome

eQHealth provides notification of review results to the provider via eQSuite®. If a review request is denied, providers and attending physicians are notified verbally and by mail or fax. Beneficiary, legal guardian or representative/responsible party denial notifications will be sent via mail.

The hospital provider, the attending physician, the beneficiary, legal guardian, or representative/responsible party may request a reconsideration of a denial determination. The ordering provider and the treating physician/clinician may contact the Medical Director to discuss the cases that have been denied or modified. A second SLR, who is board certified, and not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld or modified, the beneficiary, legal guardian, or representative/responsible party may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information.

The following table contains the details of the notification process based on review outcome.

Review Outcome	**Details**
Certification (Approval)	• Electronic notification of approval review results is sent to the provider via eQSuite®.
Denial	• If eQHealth determines services are not medically necessary and appropriate, a denial letter will be issued and reconsideration rights will apply. • Written notification of denial determination is sent to the provider, attending physician and beneficiary/representative/responsible party. • The beneficiary/representative/responsible party's notice does not contain the medical basis for the denial. • Verbal notice is provided to the provider for all review types except continued stays, where the patient has been discharged, and retrospective reviews.
Suspended	eQHealth will notify the requester (verbally and via eQSuite®) when additional information is required and the review will be pended. If the requested information is not submitted by the due date, eQHealth issues a written notice of Review Suspended.

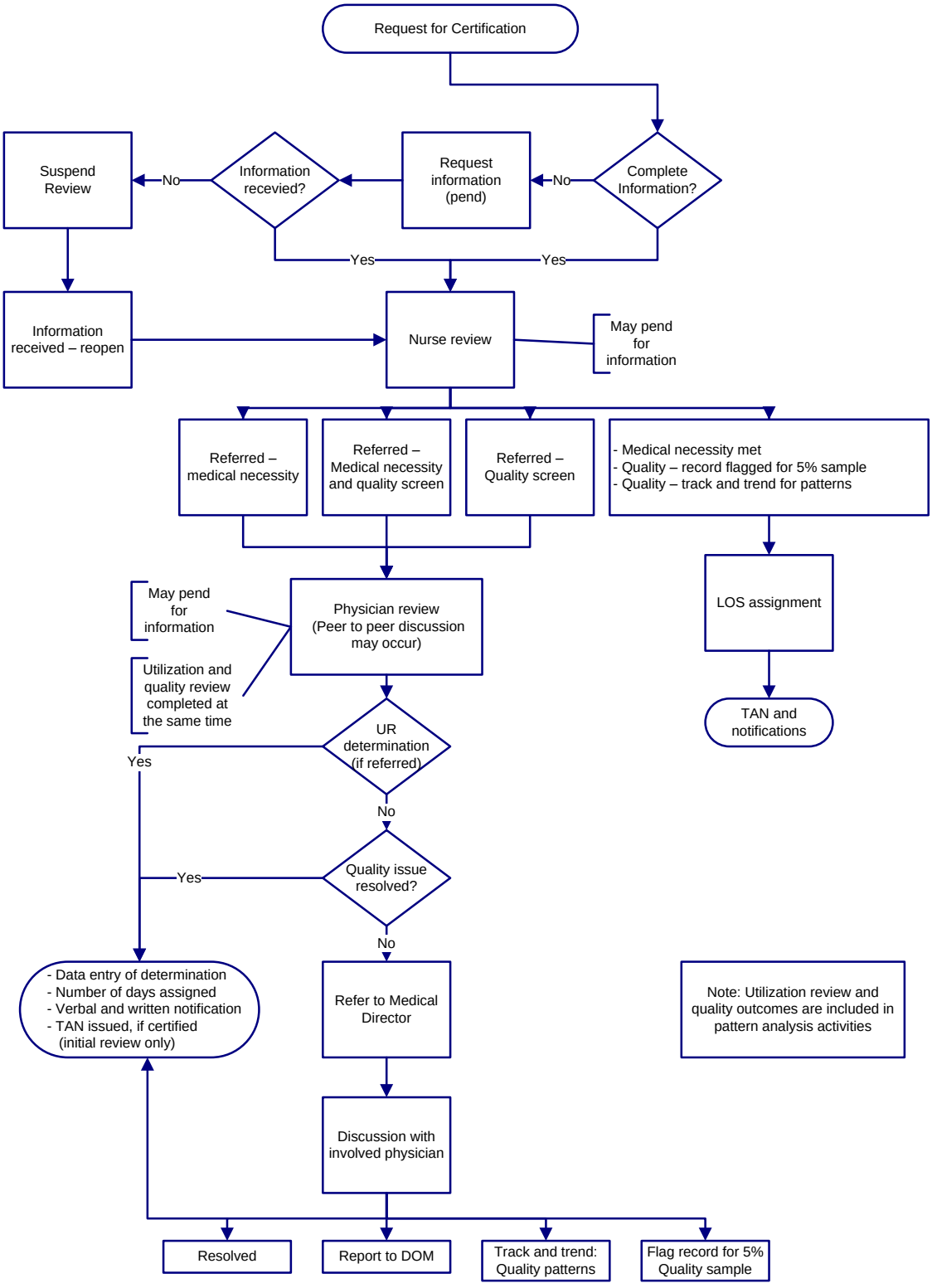
Review determination and notification timeframes are displayed in the following table.

Review Type(s)	**Review Determination and Verbal Notification**	**Written Notification**
• Planned or Elective Admission • Admission • Continued Stay • *Retro Short Stay	Within one business day of receipt of review request and necessary information.	Within one business day of review determination.
• Continued Stay – Beneficiary discharged. • Retrospective	Verbal notification is not given for this review type.	Within 20 business days of receipt of review request and necessary information.

Notices of review outcome include the following information.

Review Outcome	Information	Review Type		
		Admission	Continued Stay	Retrospective
Certification (Approval)	Date of notice.	√	√	√
	Brief statement of eQHealth's authority and responsibility for review.	√	√	√
	Reason for determination.	√	√	√
	Date(s) of service being approved.	√	√	√
	Type service certified.	√	√	√
	Number of units/days certified.	√	√	√
	Total number and type services certified to date.	√	√	√
	Total time span approved to date.	√	√	√
	Treatment Authorization Number (TAN).	√	√	√
Denial	Date of notice.	√	√	√
	Brief statement of eQHealth's authority and responsibility for review.	√	√	√
	Principal and clinical reason for denial.	√	√	√
	Type of services, number of units/days, and dates of services being denied.	√	√	√
	Total number and time span for previously certified procedures or services.		√	√
	Process for submitting a reconsideration request.	√	√	√
	Reconsideration timeframes.	√	√	√

eQHealth Review Process Flow Chart



Reconsideration Review Process

If any of the following parties disagree with the determination made by eQHealth, a request for reconsideration may be requested. The treating physician/clinician may request to speak to the Medical Director to discuss cases that have been denied or modified.

- Beneficiary/legal representative/responsible party.
- Inpatient Acute Care Provider.
- Attending physician.

A second eQHealth SLR, who is board certified, and not involved in the initial decision, will review the reconsideration request and make a determination. If the decision to deny is upheld or modified, the beneficiary/representative/ responsible party may appeal the decision directly to the Division of Medicaid.

Quality Review Process

The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving inpatient acute care services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by eQHealth. A 5% sample is also selected for reports of Maternity Admissions for Delivery. eQHealth identifies aberrant patterns and/or trends by provider.

Utilization Analysis, Focused Studies, Outcome Reports, and Proposals for Improving Health Care Delivery System

Under contract with DOM, eQHealth will conduct intensive studies of data and practice patterns. We will report the results of the studies and make recommendations for improving the health care delivery system. For this requirement we will:

- Collect and analyze Medicaid service utilization data from various sources as approved by DOM including review results data.
- Evaluate the efficiency of health care delivery, appropriate use of services, and opportunities to improve quality of care for Mississippi Medicaid beneficiaries.
- Propose, design and implement focused studies related to programs, beneficiaries, providers, services, and other topics related to Medicaid.
- Identify opportunities for improving efficiencies in various programs and provide to DOM recommendations and strategies for improving the delivery of health care.
- Provide education to providers with demonstrated aberrant utilization practice patterns or that have quality of care issues.

The identification of aberrant practice patterns and the design of appropriate projects increase the efficiency of delivery of health care and reduce gaps in quality of care of Medicaid beneficiaries.