Mississippi Medicaid – Expanded Physician Services Provider Manual

Effective Date: December 1, 2013

Revised: January 2017

Introduction: eQHealth Solutions' Expanded Physician Visits Utilization Management Program includes prior authorization of physician visits exceeding the fiscal year limit of twelve (12). Prior authorization for expanded physician visits applies to Mississippi Medicaid beneficiaries with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit; who are not enrolled in the Mississippi Coordinated Access Network, 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.

Table of Contents

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

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)
Prior authorization of anticipated expanded (greater than 12) physician visits by eQHealth Solutions is applicable for Mississippi Medicaid beneficiaries in the following eligibility categories:

- Fee-for-service EPSDT – eligible beneficiaries.
- Dually coverage, by private insurance and Medicaid.

Prior authorization by eQHealth is not required for:

- Fee for service beneficiaries who are not EPSDT eligible
- 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

Please check eligibility at each visit.

Review Questions

When a beneficiary requires expanded physician visits, the following information must be obtained in order to submit your request to eQHealth. The table below details the questions you will need to answer in our web based review system eQSuite®. ***Note: A printable version of this form can be found at*** http://ms.eqhs.org/

#	Question	Answer
1	The reason for this request is: (select all that apply)	
	My claim denied and stated service limits have been exceeded.	☐
	Service was provided and visits were available on the date(s) of service but my claim denied.	☐
	Service not yet provided	☐
	Service provided, beneficiary now retroactively eligible for Medicaid	☐
	Service provided, but not as a result of retroactive Medicaid eligibility	☐
2	Is the reason for the request a new complex problem identified within the last six (6) months? (Must be identified as the primary diagnoses on the DX/Codes/Items tab)	☐Y or ☐N

3	The beneficiary is experiencing an exacerbation in their chronic medical condition and has been unresponsive to treatment interventions.	☐Y or ☐N
4	The beneficiary is experiencing an urgent episodic medical condition/event that could be managed in an outpatient physician's office. Interventions were attempted to prevent beneficiary from experiencing an execration in their health condition or an unnecessary ER visit.	☐Y or ☐N
5	Other situation: Please explain	☐Y or ☐N

Getting to Know Mississippi Division of Medicaid (DOM) Expanded Physician Visit Coverage

For comprehensive information about expanded physician visit services covered, limitations and exclusions; the following are important resources to be familiar with:

Mississippi Administrative Code Title 23 Medicaid, Part 203, Physician Services

Mississippi Medicaid Provider Reference Guide (PRG 203)

Medicaid Physician Fee Schedule

Physician codes requiring prior authorization when a EPSDT eligible beneficiary has exhausted the state fiscal year limit of 12 visits

Code	Description
99201	New Patient Office visit Problem Focused
99202	New Patient Office visit Expanded Problem Focused
99203	New Patient Office visit Detailed
99204	New Patient Office visit Comprehensive
99205	New Patient Office visit Comprehensive
99212	Established Patient Office Visit Expanded Problem Focus
99213	Established Patient Office Visit Detailed
99214	Established Patient Office Visit Comprehensive
99215	Established Patient Office Visit Comprehensive
99241	Office or Other Outpatient Consultations (new or established patient) Problem Focus
99242	Office or Other Outpatient Consultations (new or established patient) Expanded Problem Focus
99243	Office or Other Outpatient Consultations (new or established patient) Detailed
99244	Office or Other Outpatient Consultations (new or established patient) Comprehensive
99245	Office or Other Outpatient Consultations (new or established patient) Comprehensive
99341	Home Visit Level New Patient Problem Focused
99342	Home Visit Level New Patient Expanded Problem Focused

99343	Home Visit Level New Patient Detailed
99344	Home Visit Level New Patient Comprehensive
99345	Home Visit Level New Patient Comprehensive
99347	Home Visit Level Established Patient Problem Focused
99348	Home Visit Level Established Patient Expanded Problem Focused
99349	Home Visit Level Established Patient Detailed
99350	Home Visit Level Established Patient Comprehensive
92002	Ophthalmological Visit new patient
92004	Ophthalmological Visit new patient comprehensive 1 or more visits
92012	Ophthalmological Visit established patient
92014	Ophthalmological Visit established patient comprehensive 1 or more visits

Section II – Submitting your prior authorization request:

How to submit your request

Reviews are 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 Important Service Date Specific Instructions

New Service Request/Admission

- All requests for prior authorization must be requested at least **two (2) business days** in advance of the service **or** submitted to eQHealth for review within **120 days** of the service date. All requests outside of this time frame will be cancelled.
- Service dates older than 30 days from the request date should be sent within 30 days of the service date to be processed within ***two (2) business days.***
- For service dates older than 30 days we will process these requests as quickly as possible but no later than ***twenty (20) business days.***

Retrospective Request

- For beneficiaries who are determined to be retroactively eligible, and have been discharged from care.
- Submit the review request as soon as eligibility is confirmed and within ***one (1) year*** of the retroactive eligibility determination date.
- If services are in progress when the retroactive eligibility is determined, submit an admission review request.
- For extenuating circumstances contact eQHealth Solutions.

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

- New Request/Admission review requests: 2 business days
- Retrospective review requests: 20 business days

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

Expanded Physician Visit Service 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 and thru" dates must be entered. Instructions regarding the assignment of these dates are provided within eQSuite®. The number of requested service units also must be recorded when the system does not set the default limit. DO NOT ENTER SERVICE REQUESTS BEYOND THE CURRENT STATE FISCAL YEAR, (July 1 – June 30).

Expanded Physician Visit services: The default number of units is one (1) but can be modified.

Section III – What eQHealth looks for when reviewing your request

The eQHealth Review Team, who we are:

eQHealth is a multidisciplinary team. The eQHealth Medical Director oversees the Expanded Physician Visit 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 days for admission reviews, and (10) business days for retrospective reviews. 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 days for admission reviews and ten (10) business days for retrospective reviews.
- If eQHealth does not receive the information within three (3) business days for an admission review, and ten (10) business days for a retrospective 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 Physician services:

eQHealth Solutions uses DOM approved National Clinical Guidelines (referred to as Clinical Guidelines) 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.

Section IV – IF YOU NEED INFORMATION OR ASSISTANCE

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 Expanded Physician Visit Services Utilization Management Program

For questions or information about the Expanded Physician Visit Services Utilization Management Program, the following resources are available:

- Resources available on our Web site: http://ms.eqhs.org.
  - eQHealth Expanded Physician Visit Services Provider Manual.
  - Training presentations: Copies of training and education presentations are available under the "Education" 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 Expanded Physician services. The *eQSuite® User's Guide* is available on our Web site: http://ms.eqhs.org.

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.

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.

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	A 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	eQHealth first level reviewers: • Apply DOM policy. • Apply DOM approved medical necessity clinical guidelines. • Request additional information. • Refer requests that cannot be approved for dentist review and determination. • Authorize care.

Guidelines (clinical)	The U.S. Dept. of Health and Human Services' states that clinical guidelines "…define the role of specific diagnostic 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…" 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 diagnostic or therapeutic practices have been found "to meet the needs of most patients in most circumstances", [but clinical] "…judgment…remains paramount [in developing] treatment plans that are tailored to the specific needs and circumstances of the patient." (NHLBI) Compare with "Criteria (clinical)"
International Classification of Diseases coding system	"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.
National Provider Identifier (NPI)	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.

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)	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. 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."
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.

Second Level Reviewers	eQHealth second level reviewers (SLR):
	• Make certification, denial or reconsideration determinations. That decision is:
	  ○ Based on documentation that supports prognosis and medical 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 accepted standards of healthcare.
	• Request additional information.
	• Clinically deny certification
	
	***Only a SLR can clinically deny a request*.**
	
	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.

Supporting documentation	Supporting documentation is particular documentation required at the time of an authorization request for particular services. The nature of the required documentation varies according to the type of service and may vary according to the type of authorization request.

Suspended review	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. 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 unsuspended and review is performed. (Also see "Pend (or pended) review" and "Unsuspended review".)
Treatment Authorization Number (TAN)	The acronym for "Treatment Authorization Number" is the number issued by eQHealth following the review approval process.
Upload	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.
Unsuspended review	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.)

SECTION VI – EXPANDED PHYSICIAN VISITS REVIEW WORKFLOW