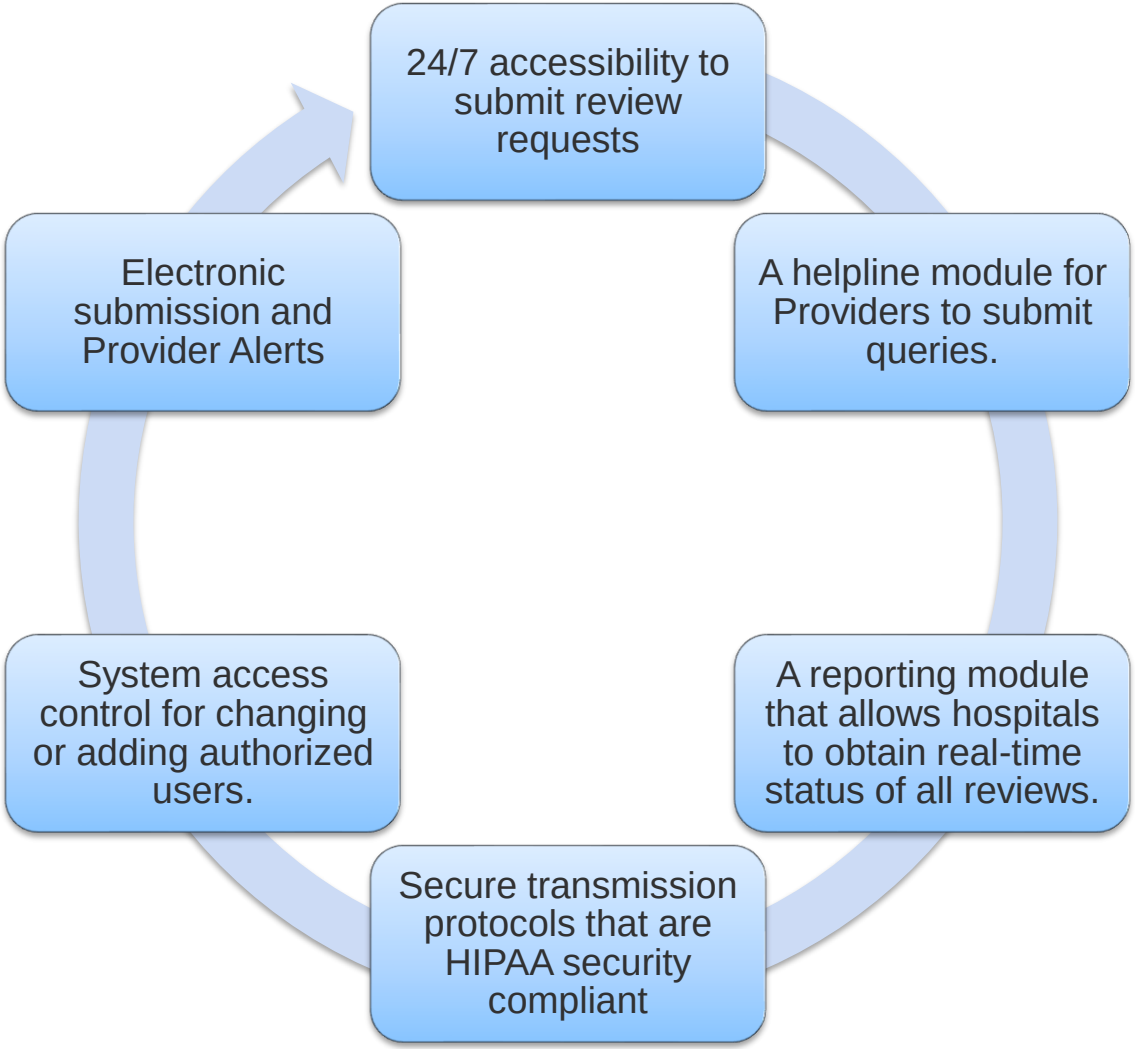
# Inpatient Services

*2019*

eq·Health solutions

# Overview of eQsuite®



# Who can access eQsuite

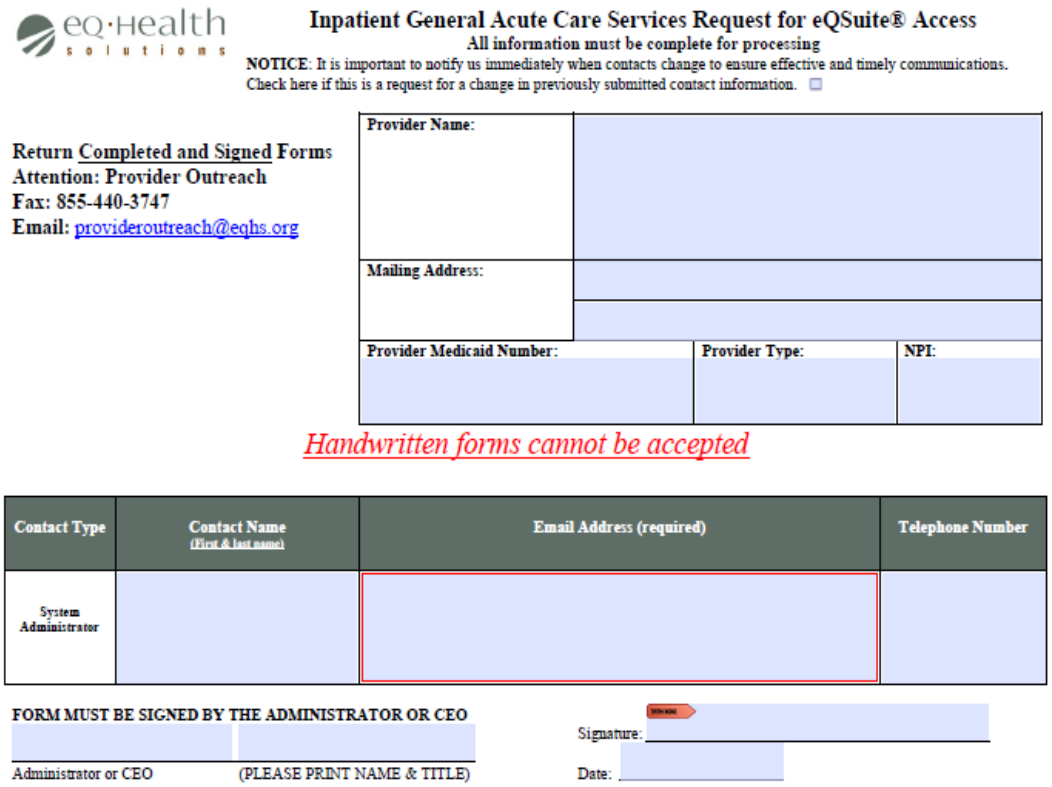
**New Users:**

**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.**



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**Inpatient General Acute Care Services Request for eQSuite® Access**

**All information must be complete for processing**

**NOTICE**: It is important to notify us immediately when contacts change to ensure effective and timely communications.
Check here if this is a request for a change in previously submitted contact information. ☐

Return Completed and Signed Forms
Attention: Provider Outreach
Fax: 855-440-3747
Email: provideroutreach@eqhs.org

| Provider Name: | | | |
|---|---|---|---|
| Mailing Address: | | | |
| Provider Medicaid Number: | | Provider Type: | NPI: |

*Handwritten forms cannot be accepted*

| Contact Type | Contact Name (First & last name) | Email Address (required) | Telephone Number |
|---|---|---|---|
| System Administrator | | | |

FORM MUST BE SIGNED BY THE ADMINISTRATOR OR CEO

Administrator or CEO (PLEASE PRINT NAME & TITLE)

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**
- **Maternal addiction program**
- **Outpatient observation**
- **Hospice related care**
- **Transplant procedures up to 1 year post transplant**
- **Elective scheduled surgeries for recipients under 21 do NOT require prior authorization.**

***Exceptions: (Bariatric Surgery, Hysterectomy, and Elective C Sections)***

- **Qualified Medicare Beneficiaries (QMB)**
- **Specified Low Income Medicare Beneficiaries (SLMB)**
- **Individuals who are inmates of public institutions on the day of admission** *(Unless there is documentation that states the inmate was released)*
- **Admissions for recipients enrolled in certain Medicaid managed care plans when the benefit plan has not been exhausted**

# Review Completion Timeframes

| Review Type | Completion Timeframe (1st Level) | Referred to Physician/Peer Reviewer (2nd Level) |
|---|---|---|
| Initial (Admission) | 1 Business day | Within 1 business day of the receipt of the complete request |
| Continued Stay | 1 Business day | 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<br>•Post Discharge<br>•Undocumented Non Citizen<br>•Medically Needy or Retroactive Medicaid Eligibility | 20 Business days<br>Note:<br>▪Review is performed when Medicaid eligibility is determined retroactively and after discharge<br>▪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 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
- ***Technical Denial*** Non compliance or inconsistency with an Agency administrative policy review
- ***Denial*** Partial and full denials are based on medical necessity and ONLY done by 2nd level physician reviewer according to Florida law
- ***Cancel*** Duplicate request, No Medicaid Eligibility

Partial and full denials have Reconsideration (Recon) and Fair Hearing rights. Recipients or their parent/legal guardian need to be aware of this Due Process. There are time limitations for requests which are outlined in the denial letters.

# Fee for Service (DRG)

| Services | Clinical Submission should include | Claim is paid |
|---|---|---|
| ▪Medical/Surgical<br>▪Acute Inpatient Psych<br>▪Inpatient Rehab | ▪The 1st Inpatient day<br>• Clearly indicate the date of admission-Do **NOT** submit clinical for observation days<br>• The state of the recipients eligibility at the time of admission will apply to the entire stay. | ▪DRG |

# Clinical Documentation

## 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.

# Undocumented Non-Citizen

| Services | Clinical submission should include | Claim paid as |
|---|---|---|
| ▪Medical/Surgical | ▪Daily clinicals for the entire length of stay | ▪PER DIEM |
| Exceptions:<br>Delivery Services | ▪Daily clinicals for the entire length of stay | ▪DRG |

**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.

# BBA Eligible

| Services | Clinical submission should include | Claim paid as |
|---|---|---|
| ▪Medical/Surgical<br>▪Acute IP Psych | ▪Daily clinicals for the entire length of stay | ▪DRG |

- 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 May 1st and the stay crosses over the fiscal year you should NOT be entering a new review.
*(Fiscal Year: July 1st-June 30th)*

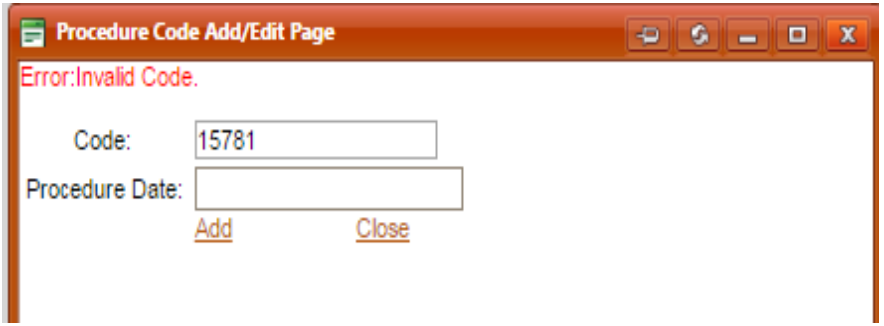
# Other Services

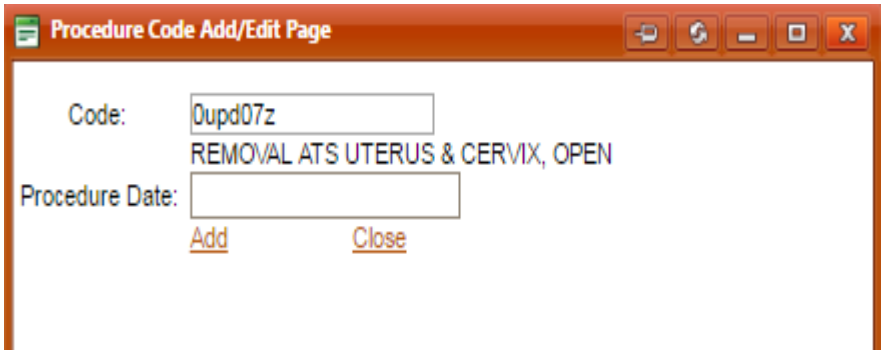
| TB (Provided by a designated provider) | SIPP (Statewide Inpatient Psychiatric Program) | Dialysis |
|---|---|---|
| ✓Clinicals should be submitted for the entire length stay<br>✓Per Diem | ✓Clinicals should be submitted for the entire length of stay<br>✓Per Diem | **Undocumented Non-Citizen:**<br>✓Clinicals should be submitted for the entire length of stay<br>✓Per Diem<br><br>**Supporting Documentation:**<br>✓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

## 2017 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
  (There is no longer a 120 day limit)
- 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