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ABOUT AHCA

THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

The Florida Agency for Health Care Administration (AHCA or Agency) was statutorily created by Chapter 20, Florida Statutes. The Agency champions accessible, affordable, quality health care for all Floridians. It is the state's chief health policy and planning entity. AHCA is the single state agency responsible for administering Florida's Medicaid program which currently serves over 2.8 million Floridians. As such it develops and carries out policies related to the Medicaid program. The Medicaid program is administered by the Agency's Division of Medicaid Services.

AHCA'S MISSION

AHCA's mission is Better Health Care for All Floridians.

ABOUT eQHEALTH SOLUTIONS

COMPANY INFORMATION, MISSION, VISION AND VALUES

eQHealth Solutions is a non-profit, multi-state health care quality improvement, medical cost management and health information technology company providing a wide range of effective and efficient solutions for our clients. Services include care coordination, utilization review, quality improvement, wellness services and quality review for home and community based waiver services. eQHealth Solutions is a leader in assisting providers to embrace health information technology (HIT) to improve the quality of care provided to patients / recipients.

Corporate Mission

"Improve the quality and value of health care by using information and collaborative relationships to enable change"

Corporate Vision

"To be an effective leader in improving the quality and value of health care in diverse and global markets"

Corporate Values

- *Pursuit of innovation;*
- *Integrity in the work we do;*
- *Sharing the responsibility for achieving corporate goals;*
- *Treating people with respect;*
- *Delivering products and services that are valuable to customer;*
- *Fostering an environment of professional growth and fulfillment;*
- *Engaging in work that is socially relevant; and*
- *Continuous quality improvement*.

eQHEALTH SOLUTIONS LOCATIONS AND CLIENTS

Florida

eQHealth Solutions was awarded the contract in 2011 by Florida's Agency for Health Care Administration (AHCA or Agency) to serve as its Medicaid Quality Improvement Organization (QIO). On behalf of the Agency, our Florida location provides diverse medical cost and quality management services in a variety of inpatient and non-inpatient settings. Our main office is located in the Tampa Bay area.

Louisiana

Under a federal contract with the Center for Medicare and Medicaid Services (CMS) since 1986-2014, our office in Louisiana serves as the state's Medicare QIO. As the Louisiana QIO, eQHealth Solutions assisted providers in achieving significant improvements quality of care in areas such as heart attack and pneumonia care, nursing home quality, home care delivery, prevention and wellness and adoption of electronic health records. Starting in 2014 as a QIO-Like entity, we provide quality improvement field – based work as a subcontractor to a regional Medicare QIN-QIO.

In 2009, we began our Senior Medicare Patrol grant with the federal Administration for Community Living (formerly AoA) to develop and implement anti-fraud efforts in Louisiana with additional awards covering the sates of Florida and Mississippi. This work is supported through our QIO infrastructure.

Mississippi

Under contract with the State of Mississippi's Division of Medicaid (DOM) since 1997, eQHealth Solutions serves as the utilization management and QIO to provide health care quality and utilization management services in a variety of inpatient and non-inpatient settings. We also perform All Patient Refined-Diagnosis Related Group validation review.

Illinois

Under contract with the Illinois Department of Healthcare and Family Services (HFS), since 2002, eQHealth Solutions serves as the Medicaid QIO, providing acute inpatient quality of care and utilization management, DRG and APR-DRG validation review.

Colorado

Under Contract with The Colorado Department of Health Care Policy and Financing (HCPF), eQHealth Solutions provides services for the ColoradoPAR (prior authorization request) program, effective September 1, 2015. Together, eQHealth and HCPF will serve Medicaid members by focusing on and implementing HCPF's mission to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.

Vermont

Since June 2015, eQHealth has been contracted with the State of Vermont, Department of Health Access, as the utilization management and the care coordination software development vendor for a CMS advance planning document grant.

ACCESSIBILITY AND CONTACT INFORMATION

This section provides information about accessing the DME review process and provides important contact information.

SUBMITTING PRIOR AUTHORIZATION (REVIEW) REQUESTS

Methods of Submission

All prior authorization (PA) review requests are submitted to eQHealth Solutions (eQHealth) through our proprietary, HIPAA-compliant web-based system, eQSuite, at http://fl.eqhs.org.

Submission requests are available 24 hours a day, seven days a week.

WHEN YOU NEED INFORMATION OR ASSISTANCE

AHCA and eQHealth are committed to delivering exceptional service to our customers. We offer a variety of ways for you to efficiently obtain the information or assistance you need. In the following sections we identify, by topic or type of assistance needed, useful resources.

For questions or information about the DME process, the following resources are available:

- Resources available on our Website: http://fl.eqhs.org:
  - Link to Most recent Florida Medicaid DME Fee Schedule listed under the DME tab.
  - This Provider Manual: DME Provider Manual
  - Training presentations: Copies of training and education presentations are available under the "Training/Education" tab.
- eQHealth Solutions customer service staff: Toll free number 855-444-3747.

Questions about Submitting PA Requests or about Using eQSuite

- *eQSuite User Guide for eQReview for Services* available on our website: http://fl.eqhs.org

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

- Check the status of a previously submitted PA request: Use your secure eQSuite login and check the information in your review status report.
- Submit an inquiry using eQSuite's helpline module. You may use it when you have a question about a previously submitted PA request.

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 contact our customer service unit.

eQHealth Solutions Customer Service

For general inquiries, inquiries that cannot be addressed through eQSuite, or if you have a complaint, contact our customer service staff.

The toll free customer service number is: 855-444-3747 (855-444-eqhs). Staff is available 8:00AM – 5:00PM Eastern Time, Monday through Friday, excluding the following State-observed holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

If you call during non-business hours, you will have the option of leaving a message. Calls received after business hours are answered by our customer staff the following business day.

If you have a complaint or compliment and would prefer to submit it in writing, send it to:

eQHealth Solutions, Inc.

Florida Division

Attention: Customer Service Department

5802 Benjamin Center Dr.

Suite #105

Tampa, FL 33634

SUBMITTING SUPPORTING DOCUMENTATION

It sometimes will be necessary to submit supporting information for authorization requests. We provide two methods for submitting supporting documentation. You may:

- Upload and directly link the information to the eQSuite review record, or
- Download eQHealth's fax cover sheet(s) and fax the information to our toll free fax number: 855-427-3747.

Requesting a Reconsideration of a Medical Necessity Denial

When eQHealth renders an adverse medical necessity determination for all or some of the requested services, the attending or treating physician, the hospital or the recipient may request reconsideration. Requests for reconsideration may be submitted:

Through eQSuite, or

- By:
  - Phone: toll free number 855-977-3747
  - Fax: toll free number 855-677-3747
  - U.S. mail, sent to:

  A reconsideration request form is posted on http://fl.eqhs.org, DME tab, Forms and Downloads folder.

  eQHealth Solutions, Inc
  Florida Division
  5802 Benjamin Center Dr.
  Suite 105
  Tampa, FL 33634

QUICK REFERENCE: CONTACT INFORMATION

- eQHealth Solutions (eQHealth)
  - Submit a prior authorization request
    - Web site (24x7): http://fl.eqhs.org
    - By fax (only for physicians without eQSuite access): toll free 855-440-3747
  - Submit additional information (24x7):
    - Upload and directly link the information to the eQSuite record, or
    - Download the eQHealth cover sheet and fax the information to our toll free number 855-427-3747
  - Submit a reconsideration review request by:
    - Web: http://fl.eqhs.org
    - Phone: 855-977-3747
    - Fax: 855-677-3747
    - U.S. mail, sent to:

      eQHealth Solutions, Inc
      Florida Division

      Attention: Customer Service Department
      5802 Benjamin Center Dr.

Suite 105
Tampa, FL 33634

- Obtain information about a previously submitted prior authorization request:

  eQSuite's provider review status reports or helpline module: available 24x7

- Customer service: 855-444-3747
  - Speak with a customer service representative 8:00 AM – 5:00 PM Eastern Time, Monday through Friday except State-approved holidays.
  - Leave a message 24x7.
  - U.S. mail, sent to:

    eQHealth Solutions, Inc
    Florida Division

    Attention: Customer Service Department
    5802 Benjamin Center Dr.
    Suite 105
    Tampa, FL 33634

SUBMISSION AND REVIEW REQUIREMENTS

eQHealth Solutions performs prior and post authorization (PA or review) for specified DME items and devices. This section provides summary information about the following authorization requirements:

- DME codes subject to review
- Submitting PA requests
- Supporting documentation
- Review request submission timeframes
- Review completion timeframes

Most DME items or devices that require medical necessity review by eQHealth Solutions must be prior authorized (before services are provided).

Services Subject to Authorization by eQHealth Solutions

Applicable Recipients

eQHealth Solutions' DME Utilization Management services are applicable for eligible Florida Medicaid recipients.

HCPCS Procedure Codes Requiring Authorization and Pricing by eQHealth

The provider fee schedule tables display the Healthcare Common Procedure Coding System (HCPCS) procedure codes for DME and medical supply services that are reimbursable by Medicaid.

Submitting Prior Authorization Requests

Review requests are submitted by the requesting DME provider electronically using eQHealth's proprietary web-based software, eQSuite.

eQSuite

Key System Features

Among eQSuite's many features are:

- Secure HIPAA-compliant technology allowing providers 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 providers 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 particular PA request.

Minimal Computer System Requirements

- Any of the two most recent versions of:
- Internet Explorer, Google Chrome, Mozilla Firefox, Safari using a Broadband internet connection.
- Minimum System Requirements

Each provider designates a user or system administrator. eQHealth assigns a user ID and password for him or her. The administrator, who need not have any information systems technical background, will have access rights to create, terminate and maintain user IDs and passwords for each user in your facility or, as applicable, physician office. Managing system access is a user-friendly, non-technical process.

Supporting Documentation

For certain HCPCS procedure codes eQSuite includes our proprietary clinical algorithms (SMART Review criteria or rules). Based on the information entered by the provider for applicable procedure codes, if the system-based medical necessity criteria are fully satisfied, the request is approved immediately upon receipt of the required supporting documentation.

If an authorization request does not satisfy all SMART Review criteria, if eQSuite cannot fully interpret the entered information, or if there are no applicable system criteria for a particular DME item, the request automatically, including the supporting documentation, is forwarded to a clinical reviewer. Documentation necessary for determining reimbursement (i.e., pricing) also must be submitted. Review will not proceed until all required documentation is submitted.

Specifically what documentation is needed and the required documentation elements depend on the type of DME and whether the item(s) must be priced.

How to Submit Supporting Documentation

You may submit supporting documentation by one of two methods:

- 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: 855-724-8322

For providers who choose to fax the documentation, we provide downloadable special fax cover sheets. Each fax cover sheet includes a bar code that is specific to the particular recipient and for the type of required information. For example, there is a specific cover sheet for the order for the DME. The review-specific fax cover sheets are available for download and printing as soon as the review request is completely entered in eQSuite.

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

Review Request Submission Timeframes

There are four types of review requests. For each type there is a specified timeframe for submitting the request.

Admission (initial authorization): Prior authorization (before service delivery) is required. Submit the PA request at least seven business days prior to service delivery. Hospital beds may be delivered prior to submission of the request for authorization. Submit the PA request within seven business days after receipt of the order.

Continued Services (Continued Stay): This is applicable only to rental DME. Submit the request at least seven business days prior to expiration of the current authorization period.

Retrospective: This type of review is applicable only for recipients who are retroactively eligible for Medicaid. Submit the review request as soon as eligibility is confirmed and within one year of the retroactive eligibility determination date. The DME provider must allow sufficient time for completion of the review process, receipt of the prior authorization number and submission of the claim prior to the end of that year.

Reconsideration review: This review is performed after an adverse determination if the ordering practitioner, DME provider, and/or recipient (or parent or legal guardian) requests review by a second eQHealth physician reviewer. Submit the request within 10 business days of the date of the outcome notification.

Review Completion Timeframes

eQHealth completes reviews within specific timeframes. The timeframe depends on the type of review. The review completion timeframe is measured from the date eQHealth receives all required information.

- Admission and continued stay review requests: 2 business days at 1st level review and 3 additional business days for 2nd level review
- Retrospective review requests: 20 business days
- Reconsideration review requests: 3 business days from the date eQHealth receives the request.

DME SERVICES REVIEW PROCESS

In this section we explain the prior authorization (PA or review) process for DME services. The type of DME requested determines the required supporting documentation. The type of review request influences the review request submission timeframe. The process for a DME service admission (initial), continued stay (rentals only) and retrospective review is the same and is explained in the first section. The process for reconsideration requests is somewhat different and is described separately.

General Review Requests

The process explained in this section is applicable for DME service admission (initial), continued stay (rentals only) and retrospective review requests.

DME Services Line Items

When DME providers submit PA requests, a separate request must be submitted for unlike items (example: requests for a wheelchair and a hospital bed for the same recipient require two separate authorization request submissions.) For custom items enter only one HCPCS code in eQSuite and itemize the component(s) for the custom item on the invoice with the corresponding HCPCS code(s). Follow the instructions in the Line Items box regarding the assignment of From and Thru dates. If the item requires pricing the total requested reimbursement for the item, including the components, must be entered.

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. If there is an eligibility issue or the services are not subject to review by eQHealth, the system will inform and prompt the user to cancel the review.

System-based Clinical Criteria First Level Review

eQSuite includes system-based medical necessity criteria for certain DME items. After a request has successfully passed the automated administrative screening, eQSuite determines whether the request may be approved through the system clinical algorithms (rules). If so, and if the applicable criteria are satisfied, the request is approved, upon receipt of the required supporting documentation, and notifications are generated. If the system's SMART Review clinical criteria are not satisfied the request is routed automatically for review by a clinical reviewer.

Clinical Reviewer Screening of the Request

When there are no review exclusions and when the request is not approved through the system-driven clinical criteria, eQSuite routes the request for first level reviewer screening and review. The clinical reviewer evaluates the entire request for compliance with applicable policies that cannot be applied by the automated process in eQSuite and for compliance with supporting documentation requirements.

Screening for Compliance with Medicaid Policies

If the clinical reviewer identifies an issue with the request related to Medicaid policy requirements, a technical determination is rendered and review does not proceed. The requesting DME provider is notified electronically through eQSuite. Since a technical determination is rendered for an administrative reason (not a clinical or medical necessity reason) it is not subject to reconsideration.

Screening for Compliance with Supporting Documentation Requirements

Supporting documentation must be submitted with requests. The documentation must be clear, legible, current, and must comply with all applicable policies.

If all required supporting documentation is not received with the request, the clinical reviewer "pends" the request. The DME provider is notified electronically that the information must be received within three business days. If it is not received within three business days the review request is suspended and the requesting DME provider is 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.

Clinical Information Screening

The clinical reviewer screens the submitted clinical information to ensure it is sufficient to complete the medical necessity review and, when applicable, to conduct pricing. 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:

- An advisory email is generated to the requesting provider. The provider accesses the review record to determine what additional information is needed.
- The requested information must be submitted within three business days.
- If eQHealth does not receive the information within three business days of the notification, the review request is suspended and no further review processing occurs.
- The provider is notified through the system status report that the request is suspended.
- If the information is submitted at a later date, eQHealth re-opens the request and reviews

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 clinical reviewer evaluates all clinical information recorded in eQSuite and evaluates the information in the supporting documentation.

Approvals

First level reviewers apply Agency-approved criteria to determine whether equipment/items 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 time frame for delivery or rental of the equipment. If an item is considered "non-classified" (shown by "0.00" in the fee schedule) eQHealth prices it.

Approval Notifications

Approval notifications are generated for all equipment or items determined to be medically necessary.

DME provider notifications

Electronic notifications are generated for DME providers.

- 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.
- We also post for the provider a draft provider notification (letter). The notification specifies the authorized item(s), the number of units and the time span for delivery or rental of the item(s) and the reimbursement amount for non-classified codes. Providers may access the notification by logging onto eQSuite. The notifications can be downloaded and printed.

Within one business day of the determination, a final copy of the determination notification is electronically posted. The final notification includes the prior authorization (PA) number. The approval information is provided to the fiscal agent.

- The fiscal agent provides the prior authorization (PA) number to eQHealth.
- Within 24 hours of our receipt of the PA number, eQHealth updates the DME provider's review status report to include the PA number.

Recipient notifications: The recipient or the child's parent or legal guardian receives written notification via mail within one business day of the determination.

Referral to a Physician Reviewer

First level reviewers may not render an adverse determination. They refer to a physician peer reviewer any authorization request they cannot approve. When the first level reviewer refers a review request to a physician reviewer the requesting DME provider's web-based status report is updated and displays the referral status.

Second Level (Physician) Review Process

The physician reviewer (PR) uses clinical experience, knowledge or generally accepted professional standards of care and judgment.

Approval Determinations and Pended Reviews

For each item the first level reviewer was unable to approve the PR determines the medical necessity of the item, the number of units requested and the time span for delivery or rental of the item(s).

- *Approval on the basis of available information*: When the available information substantiates the medical necessity of the items, number of units and the item delivery or rental time span, the PR approves the item(s) as requested and the review is completed. Notifications are issued.

- *When additional information is required*: If a PR is not able to approve the item(s) on the basis of the available information, the PR attempts to speak with the ordering practitioner to obtain additional or clarifying information. If the PR is able to authorize the item(s) on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete and notifications are issued.

- *PR pended review requests:* If the ordering practitioner is not available when the eQHealth physician calls, the PR may issue a pend determination at that time. The particular information required is documented in the review record. The requesting DME provider receives an electronic notification of the pended review.

- The information must be provided within three business days.

- If the requested information is not received within three business days, the PR renders a determination on the basis of the information that is available.

Adverse Determinations

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

Denial

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

The requesting provider receives immediate electronic notification, via the eQSuite review status report, of the denial. eQHealth will also post a draft notification of the determination in eQSuite. The provider may access it by using the eQSuite log on. The notification can be downloaded and printed.

Within one business day of the determination, the final written notification of the denial is posted electronically for the provider in eQSuite. Written notifications are mailed to the ordering practitioner and to the recipient or the recipient's parent or legal guardian.

- The written notification includes information about the practitioner's, provider's and recipient's right to a reconsideration of the adverse determination.
- The recipient's notification also includes information about his/her right to request a fair hearing.

Partial Denial

The physician reviewer 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. Therefore, there is not a complete denial of the services. An adverse determination may involve a denial of the number of units requested of the time span for rental of the item(s).

For partial denials:

- Notifications are issued to all parties.
- 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 PA number.

Reconsideration Reviews

Any party may request a reconsideration of an adverse determination. The written notification of the adverse determination includes information about the right to request a reconsideration and how to request one.

- The reconsideration must be requested within 10 business days of the date of the denial notification.
- DME providers can request reconsideration through eQSuite. Providers, ordering practitioners and recipients (or their parents or legal guardians) may submit reconsideration requests by fax, phone or mail.
- The requesting party should submit additional or clarifying information.
- Ordering practitioners and recipients (or their parent or guardian) may submit the additional information with the reconsideration request by fax, mail or phone.

Administrative Screening of Reconsideration Requests

When a reconsideration request is received it is screened to ensure it complies with policies. It must be received within the required timeframe and must be submitted by a party who is entitled to request a reconsideration. If the request does not conform to these policies:

- The request is denied.
- Notification is sent to the party who requested the reconsideration.

Processing Valid Reconsideration Requests

Only a physician peer reviewer may conduct a reconsideration review. When a valid reconsideration request is received:

- Any additional information submitted by fax or mail is linked to the review record. Information submitted by phone is documented in eQSuite.
- The review is scheduled for a physician reviewer who was not involved in the original determination.

Conducting the Review

The physician reviewer evaluates all available information including previous information and all additional information submitted. The review is performed according to the process described for all second level reviews.

Types of Determinations and Determination Implications

The reconsideration determination may be one of the following:

- **Modify:** Some of the services are approved and some continue to be denied.
- **Reverse:** The services are approved as originally requested. The original adverse determination is over-turned.
- **Upheld:** The original denial is maintained.

When the reconsideration determination results in a modification or reversal of the original determination:

The determination and notification will specify the approved item(s), units and time span for delivery or rental of the item.

- The approval information is transmitted to the fiscal agent. When a PA number was not previously issued, the provider's review status report is updated with the PA number within 24 hours of the date eQHealth received it from the fiscal agent.

- When the determination is to modify or uphold the original adverse determination, no further reconsideration is available. However the recipient (or parent or legal guardian) may request a fair hearing.

Completion Timeframe and Notifications

Reconsideration reviews are completed within three business days of receipt of a valid and complete request by eQHealth. Notifications are issued to all parties by the methods and within the timeframes described for all second level review determinations.

Fraud and Abuse Reporting

eQHealth immediately notifies the Agency of any instance of potential fraud or abuse. The Agency provides direction in what, if any, alteration in the review process is required as a result of the reported incident.

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