DURABLE MEDICAL EQUIPMENT

An Introduction to eQHealth Solutions
and the DME Authorization Process

September 2012

Introduction to eQHealth

Mission and Vision

Mission Statement:

"To Improve the Quality of Health and Health Care by Using Information and Collaborative Relationships to Enable Change"

Vision:

"*To be an Effective Leader in Improving the Quality and Value of Health Care in Diverse and Global Markets"*

Partnership: Agency for Health Care Administration and eQHealth

- eQHealth is the Agency for Health Care Administration's contracted quality improvement organization (QIO), responsible for the Comprehensive Medicaid Utilization Management Program for the state of Florida

- Local office / operations in Tampa Bay area

  5802 Benjamin Center Drive, Suite 105

  Tampa, FL 33634

- Branch office in Miami/Dade area

Dedicated Florida Website

http://fl.eqhs.org

Website demonstration

Scope of Services

Purpose

To provide equipment and supplies to eligible Medicaid recipients that are:

- Medically necessary
- Appropriate use of Medicaid benefits
- Meet AHCA approved guidelines
- Meet the requirements of the physician's order

Service Requirements

Recipients must be:

- Enrolled in a Medicaid benefit program that covers the DME/Medical Supply requested:
  - Fee for service
  - MediPass
  - Medically Needy
  - Dually eligible

- Eligible at the time services are rendered.

Exempt from Review

Recipients who are:

- Members of a Medicaid HMO
- Members of a Medicaid Provider Service Network (PSN)

Medical Necessity

Medicaid reimburses services that do not duplicate another provider's service and are medically necessary for the treatment of a specific documented medical disorder, disease or impairment.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Authorization Requirements

DME requires a prior authorization when “PA” appears in the PA column on the Florida Medicaid DME Fee Schedules. These fee schedules are posted on Florida Medicaid’s Web Portal: http://www.mymedicaid-florida.com/

- Click on “Public Information for Providers”
- Click on “Provider Support”; and then
- Click “Fee Schedules”.

Authorization Required - Example

CODE	DESCRIPTION	MAXPMT	RO	RENT	UNITS	BR	PA	LIMITS
A4421	OSTOMY SUPPLY; MISCELLANEOUS	0.00		0.00	1	BR		12 PER YEAR
A5507	FOR DIABETICS ONLY, NOT OTHERWISE SPECIFIED MODIFICATION (INCLUDING FITTING) OF OFF-THE-SHELF DEPTH-INLAY SHOE OR CUSTOM-MOLDED SHOE, PER SHOE	0.00		0.00	2	BR		2 PER FOOT PER YEAR
A9900	MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF	0.00		0.00	1	BR		MEDICAL NECESSITY
B4157	ENTERAL FORM.,NUTRI.COMP.,FOR SPEC.METAB.NEED FOR INHERITED DIS. OF METAB., INC. PRO., FATS, CARBS., VITS. & MINS., MAY INC. FIBER, ADMIN. THRU TUBE, 100 CAL.= 1	0.00		0.00	930	BR		930 PER MONTH
B4157SC	ENTERAL FORM., NUTRI. COMP., FOR SPEC. METAB. NEED FOR INHERITED DIS. OF METAB., INC. PRO., FATS, CARBS., VITS. & MINS., MAY INC. FIBER, ADMIN. ORALLY , 100 CAL. = 1 UNIT	0.00		0.00	930	BR		930 PER MONTH
E0485	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABL	0.00		0.00	1	BR		1 PER YEAR
L0999	ADDITION TO SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	0.00		0.00	1	BR		MEDICAL NECESSITY
L1499	SPINAL ORTHOSIS, NOT OTHERWISE SPECIFIED	0.00		0.00	1	BR		MEDICAL NECESSITY
L2999	LOWER EXTREMITY ORTHOSES, NOT OTHERWISE SPECIFIED	0.00		0.00	1	BR		MEDICAL NECESSITY
L3257	ORTHOPEDIC FOOTWEAR, ADDITIONAL CHARGE FOR SPLIT SIZE	0.00		0.00	1	BR		3 PER YEAR
L3649	ORTHOPEDIC SHOE, MODIFICATION, ADDITION OR TRANSFER, NOT OTHERWISE SPECIFIED	0.00		0.00	1	BR		MEDICAL NECESSITY
L3999	UPPER LIMB ORTHOSIS, NOT OTHERWISE SPECIFIED	0.00		0.00	2	BR		MEDICAL NECESSITY
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS	0.00		0.00	1	BR		LIMITED TO $160 PER YEAR
L5999	LOWER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	0.00		0.00	0	BR		MEDICAL NECESSITY
L6703	TERMINAL DEVICE, PASSIVE HAND/MITT, ANY MATERIAL, ANY SIZE	0.00		0.00	2	BR		2 PER 4 YEARS
L6706	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE,	0.00		0.00	2	BR		2 PER 4 YEARS
L6707	TERMINAL DEVICE, HOOK, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE,	0.00		0.00	2	BR		2 PER 4 YEARS
L6708	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY OPENING, ANY MATERIAL, ANY SIZE	0.00		0.00	2	BR		2 PER 4 YEARS
L6709	TERMINAL DEVICE, HAND, MECHANICAL, VOLUNTARY CLOSING, ANY MATERIAL, ANY SIZE	0.00		0.00	2	BR		2 PER 4 YEARS
L6882	MICROPROCESSOR CONTROL FEATURE, ADDITION TO UPPER LIMB PROSTHETIC	0.00		0.00	1	BR		2 PER 2 YEARS
L7499	UPPER EXTREMITY PROSTHESIS, NOT OTHERWISE SPECIFIED	0.00		0.00	2	BR		MEDICAL NECESSITY
L7520	REPAIR PROSTHETIC DEVICE, LABOR COMPONENT, PER 15 MINUTES	0.00		0.00	0	BR		MEDICAL NECESSITY
L8499	UNLISTED PROCEDURE FOR MISCELLANEOUS PROSTHETIC SERVICES	0.00		0.00	0	BR		MEDICAL NECESSITY
[illegible]								
E0250	HOSPITAL BED, FIXED HEIGHT, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	795.40		79.54	1		PA	1 PER 8 YEARS
E0255	HOSPITAL BED, VARIABLE HEIGHT, HI-LO, WITH ANY TYPE SIDE RAILS, WITH MATTRESS	853.60		85.36	1		PA	1 PER 8 YEARS
E0303	HOSPITAL BED, HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 350	2414.10		241.41	1		PA	1 PER 8 YEARS
E0482	**COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE**	**5288.00**		**0.00**	**1**		**PA**	**MEDICAL NECESSITY**
E0483	**HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR**	**10676.25**		**0.00**	**1**		**PA**	**MEDICAL NECESSITY**
E0784	**EXTERNAL AMBULATORY INFUSION PUMP, INSULIN**	**0.00**		**0.00**	**1**		**PA**	**MEDICAL NECESSITY**
E0955	WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, ANY TYPE, INCLUDING FIXED MOUNTI	161.74		0.00	1		PA	1 PER 3 YEARS
E0956	WHEELCHAIR ACCESSORY, LATERAL TRUNK OR HIP SUPPORT, ANY TYPE, INCLUDING FIX	78.86		0.00	6		PA	6 PER 3 YEARS
E0957	WHEELCHAIR ACCESSORY, MEDIAL THIGH SUPPORT, ANY TYPE, INCLUDING FIXED MOUNT	110.34		0.00	1		PA	1 PER 3 YEARS
[illegible]								

Review Requests

Review Requests

Prior to submitting a review, verify that:

- ✓ The recipient's Medicaid eligibility
- ✓ The item is:
  - -A covered Medicaid benefit
  - -Required to be prior authorized
- ✓ The required supporting documentation is:
  - -Complete
  - -Legible
  - -Appropriately signed and dated

Review Requests

Types of Review Requests:

- Admission (initial authorization)
- Continued Services (Continued Stay)
  - *applicable only to rental DME*
- Retrospective
  - *applicable only for recipients who are retroactively eligible for Medicaid*
- Reconsideration review
  - *response to an adverse determination*

Review Requests

Prior authorization must be obtained prior to the delivery of equipment or supplies.

Exceptions

- Hospital beds:
  - Order for the bed must be obtained within **21 days** of delivery.
  - Authorization requests must be submitted within **7 days** of receipt of the signed order.
- Retrospective Medicaid eligibility:
  - Authorization must be obtained prior to billing.
  - Claims must be billed within 12 months of determination of eligibility.

Review Requests

Prior Authorization Number (PA #) Assignment

- Purchased Items: 120 day PA time span
- Rental Items: Up to 10 months
  - Rentals cannot exceed 10 months.
  - Time spans will be authorized based on medical necessity determinations.
  - Authorization time span will not exceed the requested time span.

Request Submission & Review Completion Timeframes

Type of Request	Submission	Review Completion Timeframes
Admission/Initial	At Least 7 days prior to the expected delivery date	1St Level - 2 business days 2nd Level - 3 additional business days
Continued Service (Continued Stay)	7 business days prior to the expiration of the current authorization	
Reconsideration	Within 10 days of the notification letter	3 business days
Retrospective	Within 12 months of the eligibility determination	20 business days

First Level Review Screening

Systematic verification that there are no review exclusions:

- Recipient is not eligible for part of the requested timeframe;
- Duplication of item;
- Request does not meet the replacement time span requirement; or
- Requested service is not covered by Medicaid.

Review Determination Process

- **System-based Clinical Criteria First Level Review**

  Based on the diagnosis and the item requested, an "automatic authorization" based on clinical algorithms is issued.

- **Clinical Reviewer Screening**

  If the request is not approved through the system-driven clinical algorithms the request is forwarded to a first level clinician reviewer.

Review Determination Process

First Level Clinicians may:

- Approve the request
- Issue a technical denial of the request, if appropriate
  - Duplicative service
  - Noncompliant with Medicaid policy
- Pend the request back to the provider for:
  - Additional or clarifying information
  - Supporting documentation
  - Re-pricing of a line item
- Refer the request to a second level physician reviewer

Review Determination Process

Pended Requests

- An advisory email is generated to the requesting provider.
- The provider accesses the review record to determine what additional information is needed.
- The information should be submitted within 3 business days.

Second Level Review

- Physician peer reviewers base their determination on generally accepted professional standards of care, their clinical experience and judgment, Medicaid's medical necessity criteria, and peer to peer consultation with the ordering physician when necessary.

- Physician reviewers may render an approval or an adverse determination.

- An adverse determination may be a full denial of the requested items/services or a partial denial of the requested items/services.

Review Determination Notification

Determination notifications are issued to providers, physicians, and recipients within one (1) business day of the determination.

- An electronic advisory message is immediately issued for the requesting provider.
- A written notification of the determination is posted on eQSuite.
- Notification may be downloaded and printed.
- The recipient, or legal guardian, receives written, mailed notification.

Ordering providers receive written, mailed notification of adverse determinations.

Review Determination Notification

Notifications include:

- Equipment/Supplies approved or denied;
- Reason for an adverse determination;
- Rights to a reconsideration and how to request one; and
- Recipient's right to a fair hearing and how the recipient may request one.

Reconsiderations

Any party involved in the case may request a reconsideration of an adverse determination:

Requesting Provider:

- eQSuite (electronic)

Recipient, Legal Guardian, or Ordering Provider:

- Phone
- Mail
- Fax

Reconsiderations

A physician reviewer, not involved in the original adverse determination, will:

- Uphold the original adverse determination;
- Modify the original determination, approving a portion of the items/services requested; or
- Reverse the original determination, approving all the items/services requested.

Reconsideration reviews are completed within three (3) business days of receipt of a complete and valid request.

Please Note: When requesting a reconsideration, new and/or additional clinical information must be submitted.

Fair Hearings

Recipients or their legal representatives, may appeal an adverse determination by requesting a fair hearing.

The request may be submitted within 90 days from the date of the adverse notification letter by calling or writing:

- The local Medicaid area office; or
- Department of Children Families Office of Appeals and Hearings

Required Supporting Documentation

Supporting documentation is determined by AHCA policy and is required to substantiate the necessity of items/services.

All supporting documentation must be submitted with the request for authorization for DME.

Required Supporting Documentation

REQUIRED DOCUMENT	COMMENTS
Prescription/Order	Examples: •Prescription/order •Hospital discharge summary (if discharged within past 30 days) •Certificate of Medical Necessity
Supporting Documentation	Required for all requests*. Note that there are additional special requirements for AAC devices and custom wheelchairs.
Pricing Information/Invoice	Required*
Plan of Care	Home Health Providers Only

*For further details, please refer to the Florida Medicaid DME Provider Handbook.

Submitting Supporting Documentation

Options for submitting documentation:

1. Upload and directly link the information to the eQSuite review record.

2. Download eQHealth bar coded fax cover sheet(s) when prompted and submit the information using our 24/7 toll free fax line.

Submitting Supporting Documentation

Each fax cover sheet includes a bar code that is specific to the particular recipient and the type of required information.

Do not copy or reuse fax cover sheets.

The review-specific cover sheets are available for downloading and printing as soon as the review request is completed and entered into eQSuite.

You must use only the assigned fax cover sheet for the specific type of supporting documentation.

eQSuite

eQSuite

Proprietary eQHealth web-based software:

- Secure HIPAA-compliant technology allows providers to record and transmit information necessary to obtain authorizations.
- 24/7 availability

eQSuite

Minimal Computer System Requirements:

- Intel Pentium 4 or higher CPU and monitor;
- Windows XP SP2 or higher;
- 1 GB free hard drive space;
- 512 MB memory;
- Internet Explorer 7 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher; and
- Broadband internet connection.

eQSuite Functions

- Create new reviews
- Respond to requests for additional information
- Submit documentation
- Respond to adverse determinations
- Search for authorization requests/reviews
- Enter discharge dates (rentals only)
- View and download reports and letters
- Online Helpline
- Control system access
- Update user profiles

eQSuite Live Demonstration

Access to eQSuite

- All Medicaid participating DME providers must have a contact form appropriately filled out and faxed to eQHealth to receive log on information.

- If you are already an eQSuite user, apply for an additional DME logon.

Access Contact Form at: *http://fl.eqhs.org*

Therapy/DME Tab, Select Provider Communication

Durable Medical Equipment Contact Form

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. ☐

Attention: Florida Medicaid Providers of Durable Medical Equipment (DME)

Return Completed and Signed Form
By Fax: 855-440-3747, Attention: Provider Outreach
By Email (signed, scanned forms only)
provideroutreach@eqhs.org

Provider Name:		
Mailing Address:		
Medicaid Provider#		**NPI#:**

Please complete the following table and provide the requested information for each Contact Type.

DME Services Contact Type Descriptions:

1. ***Administrator or Owner*** *– This person is in charge of the organization. This individual will receive general correspondence from eQ Health Solutions, provider bulletins, and contact forms.*
2. ***Assigned eQ Health Liaison*** *– This person will be the main contact for receipt of information from eQ Health Solutions regarding the Medicaid Comprehensive Utilization Management Program prior authorization requirements for DME services. Also, this person is someone we can contact to obtain necessary information regarding the provider.*
3. ***System Administrator*** *– This person is responsible for management of user IDs for the DME provider's representatives' access to eQ Health's prior authorization review system, eQ Suite. This includes day-to-day administration of creation, deletion, and modification to user information and rights.*

Contact Type	Contact Name	Prof. Suffix	Title	Mailing Address (If different from above)	Email Address	Telephone and Fax Numbers
Administrator or Owner						T: F:
Assigned eQ Health Liaison						T: F:
System Administrator						T: F:

FORM MUST BE SIGNED BY:
THE ADMINISTRATOR/OWNER, OR IF NOT APPLICABLE, BY THE PRIVATE (INDEPENDENT) DURABLE MEDICAL EQUIPMENT PROVIDER.

_____
Administrator or Owner or Independent Durable Medical Equipment Provider (PLEASE PRINT NAME & TITLE)

Signature: _____ Date: _____

Transition

- 9/14/12: Last date to submit requests to AHCA
- 9/26/12: First date to submit requests to eQHealth
- 10/1/12: eQHealth begins reviewing DME requests

Provider Communications and Resources

- Online Helpline
- Customer Service: 885-444-3747

  Monday-Friday, from 8 a.m.–5 p.m. Eastern Time
- Dedicated Florida Provider Website http://fl.eqhs.org
- Blast Emails
- eQSuite Notices

Questions and Answers

Thank-you for attending

Your opinion is important to us. Please complete the survey which will appear on your computer when the webinar ends.