Dental Services Provider Manual

eq·Health solutions
# Table of Contents

## ABOUT AHCA AND FLORIDA MEDICAID

The Florida Agency for Health Care Administration .......................................................... 1  
Medicaid Utilization Management: Legal Authority ......................................................... 1

## ABOUT eQHEALTH SOLUTIONS

Company Information, Mission, Vision and Values ............................................................ 2  
Corporate Mission ............................................................................................................. 2  
Corporate Vision ............................................................................................................... 2  
Corporate Values ............................................................................................................. 2  
eQHealth Solutions Locations and Clients ........................................................................ 2

## ACCESSIBILITY AND CONTACT INFORMATION

When You Need Information or Assistance ......................................................................... 4  
Submitting Supporting Documentation ............................................................................. 5  
Requesting a Reconsideration of a Medical Necessity Denial .......................................... 6

## REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

Services Subject to Authorization by eQHealth Solutions .................................................. 7  
Submitting Prior Authorization Requests by Web ............................................................. 8  
Submitting Prior Authorization Requests by Means Other than Web ............................. 8  
Supporting Documentation Requirements and Submission .............................................. 9  
Review Request Submission Timeframes ....................................................................... 9  
Review Completion Timeframes ..................................................................................... 10

## DENTAL SERVICES REVIEW PROCESS

General Review Requests ................................................................................................. 11  
Dental Service Line Items ............................................................................................... 11  
Automated Administrative Screening .............................................................................. 11  
Clinical Reviewer (1st Level) Screening of the Request .................................................. 12  
First Level Medical Necessity Review Process .................................................................. 13  
Second Level (Dentist) Review Process ........................................................................... 14  
Reconsideration Reviews ............................................................................................... 15  
Fraud and Abuse Reporting ............................................................................................ 16
ABOUT THE AGENCY FOR HEALTH CARE ADMINISTRATION AND FLORIDA MEDICAID

The Florida Agency for Health Care Administration

The Florida Agency for Health Care Administration (AHCA or Agency) is the single state agency responsible for administering Florida’s Medicaid program which currently serves over 3 million Floridians.

Medicaid Utilization Management: Legal Authority

Both Federal regulations and State statutes require implementation of utilization management strategies for Medicaid health care services. The Code of Federal Regulations 42 C.F.R. 456 directs states to implement utilization controls that safeguard against unnecessary or inappropriate use of Medicaid services, protect against excess payments and assess the quality of health care services.

In addition to requirements in 42 CFR 456, dental services are governed by 42 CFR, Parts 440.100, 440.50, 440.120, and 440.30. The Florida Medicaid dental services program is implemented through section 409.906, Florida Statutes (F.S.). The Florida Administrative Code (F.A.C.), Rule 59G-4.060, implements the limitations for Medicaid dental services.

In fulfilling its statutory obligations, AHCA has contracted with eQHealth Solutions to implement a utilization management program for certain dental services. eQHealth Solutions (eQHealth) is a federally designated Quality Improvement Organization (QIO).
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/recipient.

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 utilization and quality management services for a variety of inpatient and non-inpatient settings. Our main office is located in the Tampa area.

Louisiana

Under a federal contract with the Centers for Medicare and Medicaid Services (CMS) since 1986, our office in Louisiana serves as the state’s Medicare QIO. As the Louisiana QIO, eQHealth Solutions assists providers to achieve significant improvements in areas such as heart attack and pneumonia care, nursing home quality, home care delivery, prevention and wellness and adoption of electronic health records.
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.

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, designing and conducting quality of care studies and performing quality review services for home and community based waiver services.

For more information about eQHealth Solutions visit www.eqhealthsolutions.com or http://fl.eqhs.org (Florida specific information).
ACCESSIBILITY AND CONTACT INFORMATION

eQHealth Solutions’ Dental Services Utilization Management Program includes prior authorization of certain prosthodontic and orthodontic services for Medicaid recipients in defined eligibility categories.

When You Need Information or Assistance

We offer a variety of ways for you to obtain the 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 Dental Services Utilization Management Program

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

资源 available on our Web site: [http://fl.eqhs.org](http://fl.eqhs.org):
- Dental Services Provider Manual. There also are manuals for other eQHealth utilization management programs.
- Training presentations: Copies of training and education presentations are available under the “Training/Education” tab.
- Frequently Asked Questions (FAQs): The FAQs are under the “Dental” tab.

eQHealth’s customer service staff: Toll free number 855-444-3747. (See “eQHealth Solutions Customer Service” for hours of operation.)

Questions about Using our Web-based Review System

eQSuite™ is our proprietary Web-based review system. It is used to submit PA requests for prosthodontic and orthodontic services. The eQSuite™ User’s Guide - Dental Services is available on our Web site: [http://fl.eqhs.org](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. 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. (See “eQHealth Solutions Customer Service”.)

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. Our toll free customer service number is 855-444-3747. Staff are 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 have the option of leaving a message. Calls received after business hours are answered by our customer service staff the following business day.

If you have a complaint and would prefer to submit it in writing, please send it to our toll free customer service fax number: 855-440-3747. Or mail it to:

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

**Obtain Comprehensive Information about Florida Medicaid Policies**

For comprehensive information about Medicaid dental services coverage, limitations and exclusions, administrative policies and claims submission, there are a number of important resources:

- Florida Provider General Handbook
- Florida Medicaid Dental Services Coverage and Limitations Handbook
- Florida Medicaid Provider Reimbursement Handbook, American Dental Association (ADA)
- Florida Medicaid Provider Reimbursement Handbook, CMS-1500
- Dental Provider Reimbursement Schedule which includes the Dental General Fee Schedule and the Dental Oral/Maxillofacial Surgery Fee Schedule.

All handbooks and fee schedules are available through the following Web links:

- [http://portal.flmminus.com/FLPublic](http://portal.flmminus.com/FLPublic)
  - Click on Provider Support, then
  - Click on Provider Handbooks or on Fee Schedules
- We also provide a link to the handbooks and fee schedules from our Web site at [http://fl.eqhs.org](http://fl.eqhs.org).

**Submitting Supporting Documentation**

Orthodontic services review requests must be accompanied by certain diagnostic records supporting the need for services. For prosthodontic services eQHealth may request supporting documentation. (See Section II – Review Requirements and Submitting PA Requests, Supporting Documentation.) The supporting documentation should be submitted electronically by:

- Uploading and directly linking the documentation to the review record, or
- Downloading our fax cover sheet(s) and faxing the documentation to our toll-free fax number: 855-409-1521.

If any required documentation cannot be sent electronically (for example, non-digitalized radiographs or requested study models), submit it by mail to:

eQHealth Solutions, Inc.
Florida Division
5802 Benjamin Center Drive, Suite #105
Tampa, FL 33634
Requesting a Reconsideration of a Medical Necessity Denial

If eQHealth renders a medical necessity denial for all or some of the requested services, the treating dental or orthodontic provider and the recipient (or parent or legal guardian) may request a reconsideration of the decision. Requests may be submitted by:

- Phone: toll free number 855-977-3747
- Fax: toll free number 855-677-3747
- U.S. mail, sent to:
  eQHealth Solutions  
  Florida Division  
  5802 Benjamin Center Dr.  
  Suite 105  
  Tampa, FL 33634

Providers may also submit requests through our Web site: [http://fleqhs.org](http://fleqhs.org).

**Important Notice:** Do not send or submit Protected Health Information (PHI) to eQHealth Solutions via email. Please use the Provider Helpline Module within eQSuite™ for submitting inquiries.
REVIEW REQUIREMENTS AND SUBMITTING PA REQUESTS

On behalf of AHCA, eQHealth Solutions performs prior authorization (PA or review) for certain prosthodontic and orthodontic services. This section provides summary information about the following authorization requirements:

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

Services Subject to Authorization by eQHealth Solutions

Applicable Recipients

eQHealth Solutions’ prosthodontic and orthodontic utilization management services are applicable for Florida Medicaid recipients in the following eligibility categories:

- Fee-for-service, including those who have third party coverage
- MediPass recipients who are not in enrolled in an HMO, a PSN or the Prepaid Dental Health Program (PDHP)
- Dually eligible (eligible for both Medicare Part B and Medicaid)
- Medically needy (share of cost)

Essential References

- The Florida Medicaid Dental Services Coverage and Limitations Handbook provides comprehensive information about covered dental services for adults and children under 21 years of age and about authorization requirements. Use it in combination with the:
  - Florida Medicaid Provider General Handbook and the
  - Florida Medicaid Provider Reimbursement Handbook
  - American Dental Association (ADA).
- The Dental Provider Reimbursement Schedule contains information about which services are reimbursable by Florida Medicaid, the maximum reimbursable service units and fees payable by Medicaid, whether the services are limited to recipients under age 21 years and the services that require prior authorization. For information about prosthodontic and orthodontic services refer to the Dental General Fee Schedule.

The handbooks and fee schedule are available at http://portal.flmmis.com/FLPublic, Select Provider Support and click on Provider Handbooks or Fee Schedules. eQHealth also provides a link to the handbooks and fee schedule from our Web site at http://fl.eqhs.org.

CDT © 1 Procedure Codes Requiring Prior Authorization

The CDT © procedure codes subject to review by eQHealth Solutions are included in the Dental General Fee Schedule. Codes having a “Y” in the “PA” column require prior authorization.

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1 Current Dental Terminology (CDT) © (including procedure codes and descriptions) is copyrighted by the American Dental Association. All rights reserved.
Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for detailed coverage and limitations information and prior authorization requirements. Also refer to the Dental General Fee Schedule for summary information about service eligibility limitations and the maximum number of reimbursable service units.

**Submitting Prior Authorization Requests by Web**

Review requests for prosthodontic and orthodontic services are submitted electronically using eQHealth's propriety Web-based software, eQSuite™.

**eQSuite’s™ Key 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 System Requirements**

Providers’ system requirements for using eQSuite™ are minimal:

- 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 7 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher
- Broadband internet connection

eQHealth Solutions will provide information that will explain everything you need to know to access eQSuite™.

Each provider designates a system administrator, and eQHealth will assign 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 and maintain user IDs and passwords for each user in your company. Managing system access is a user-friendly, non-technical process.

**Submitting Prior Authorization Requests by Means Other than Web**

For dental practices that do not use computers in their day-to-day operations, please contact eQHealth’s customer service staff at 855-444-3747. We will assist with the processing of your requests.
Supporting Documentation Requirements and Submission

Required Documentation

Documentation substantiating the need for orthodontic services must be submitted with the review request. For information about what supporting documentation is required, go to our Web site: http://fl.eqhs.org. Click on the Dental tab and then Forms and Downloads. We also include in eQSuite™ reminders about what documentation is required. For prosthodontic services eQHealth may, at its discretion, request supporting documentation including but not limited to radiographs. When documentation is required or is requested by eQHealth review will not proceed until it is received.

How to Submit Supporting Documentation

The supporting documentation should be submitted electronically using 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: 855-409-1521.

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 Initial Assessment Form (IAF) required for orthodontic services. The review-specific fax cover sheets are 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 RECIPIENT AND ARE SPECIFIC TO THE TYPE OF DOCUMENT.**

If any required documentation cannot be sent electronically (for example, non-digitalized radiographs), submit it by mail to:

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

Review Request Submission Timeframes

Types of Review Requests

There are four types of review requests. One is applicable only to orthodontic services. For each type there is a specified timeframe for submitting the request.

- **Admission** (initial authorization): Prior authorization is required. Submit the PA request at least ten business days prior to the planned service date.
- **Modification**: This is applicable only for orthodontic services. It is the review type when an extension of the previously approved maximum 24 service units (visits) is needed within an active/current authorization period. Submit the request as soon as the need for additional units is identified, before additional visits are incurred and before expiration of the current authorization period. (Please note that the authorization period cannot be extended. Only medically necessary units (visits) beyond 24 may be authorized.)
Retrospective: This type of review is applicable only for recipients who are determined to be retroactively eligible for Medicaid and the recipient has been discharged from care (services are completed).

- Submit the review request as soon as eligibility is confirmed and within one year of the retroactive eligibility determination date. The claim must be submitted within 12 months of the eligibility determination date, and the provider must allow sufficient time for completion of the review prior to submission of the claim.
- If services are in progress when the retroactive eligibility is determined, submit an admission review request.

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

Considerations if a Recipient Transfers from One Provider to Another During Active Orthodontic Treatment

If a recipient transfers from one provider to another the services rendered by the new provider must be prior authorized.

- Submit an admission review request when the recipient’s eligibility is active or when it is determined retroactively and the services are in progress at the time eligibility is confirmed.
- Submit a retrospective review request if the recipient’s eligibility is determined retroactively and (s)he has been discharged from care when eligibility is granted.

Because orthodontic services have a once per lifetime benefit limit, eQSuite™ will prompt the practitioner to provide information about the recipient’s prior utilization history, if known. For additional information refer to the Dental Services Authorization Process training material under the Training/Education tab of our Web site (http://fl.eqhs.org) or to The eQSuite™ User’s Guide - Dental Services, also available on our Web site.

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 review requests: 3 business days at 1st level review and 2 additional business days for 2nd level review
- Modification review requests: 3 business days at 1st level review and 2 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.
DENTAL SERVICES REVIEW PROCESS

In this section we explain the prior authorization (PA or review) process for prosthodontic and orthodontic services. The type of service determines whether supporting documentation always is required or whether it may be requested by eQHealth. The type of review request influences the review request submission timeframe. (Refer to Section II: Review Requirements and Submitting PA Requests.) The process for an admission (initial), modification 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 admission (initial), modification and retrospective review requests. Providers are encouraged to review the PA requirements information in Section II of this manual and to be thoroughly familiar with the information in the applicable Florida Medicaid handbooks and fee schedules.

**Dental Service Line Items**

When providers submit PA requests, each CDT 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.

- **Prosthodontic services**: The default number of units is one and cannot be edited.
- **Orthodontic services**: Except as noted below for procedure code D8670 (periodic orthodontic treatment visits) and for modification review requests, the maximum number of units requested cannot exceed the maximum allowable benefit discussed in the Florida Medicaid Dental Services Coverage and Limitations Handbook and shown in the Dental General Fee Schedule.
  - For code D8670, when an admission review is requested for a recipient who has not previously received orthodontic services, a maximum of 24 visits (units) over 36 months may be requested.
  - For retrospective reviews involving D8670, where orthodontic services have been completed, the number of units must equal the total units (visits) provided.
  - For a modification review request, specify the number of units (visits) exceeding those currently approved.

There is a special consideration for the orthodontic procedure code D8999 (unspecified orthodontic procedure). A PA request for code D8999 always must include an authorization request for procedure code D8670 (periodic orthodontic treatment visit). If the request does not include code D8670 review will not be performed.

**Automated Administrative Screening**

When the 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 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 for first level reviewer screening and review. The clinical reviewer evaluates the entire request for compliance with applicable Medicaid policies that cannot be applied by the automated process 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 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 all orthodontic services requests. The documentation must be clear, legible, current, and must comply with all applicable Medicaid policies. For information about supporting documentation requirements refer to Section II: Prior Authorization Requirements: Submission and Review Requirements.

If all required supporting documentation is not received with the request, the clinical reviewer “pends” the request. The provider is notified electronically that the information must be received within five business days. If it is not received within five business days the request is suspended and the requesting 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. (Also see “Clinical Information Screening and Pended and Suspended Review Requests”.)

Clinical Information Screening and Pended and Suspended Requests

Clinical Information Screening

The clinical reviewer screens the submitted clinical information to ensure it is sufficient to complete the medical necessity review. 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 five business days.

If eQHealth does not receive the information within five 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 the services beginning from the date the complete information was received.
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 all submitted supporting documentation information.

Approvals

First level reviewers apply Agency-approved criteria 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.

Approval Notifications

Approval notifications are generated for all prosthodontic and orthodontic services determined to be medically necessary.

Provider notifications: Electronic notifications are generated for the treating 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.
  - We also post for the provider a draft provider notification (letter). The notification specifies the authorized service(s), the number of units and the authorization period. Providers may access the notification by logging onto eQSuite™. The notifications may 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 Medicaid 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 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 Dental Reviewer

First level reviewers may not render an adverse determination. They refer to a dental peer reviewer any authorization request they cannot approve. When the first level reviewer refers a review request to a dental reviewer the requesting provider’s Web-based status report is updated and displays the referral status.
Second Level (Dentist) Review Process

The dentist peer reviewer (PR) uses clinical experience, knowledge of generally accepted professional standards of care and judgment. The PR considers whether the service(s) for which authorization is requested:

- Are eligible for reimbursement under Florida Medicaid policy.
- Conform to the Agency’s definition of medical necessity and other coverage criteria specified in the applicable Florida Medicaid provider handbooks.

Approval Determinations and Pended Reviews

For each service the first level reviewer was unable to approve the PR 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 PR approves them as requested and the review is completed. Notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.
- When additional information is required: If a PR is not able to approve the service(s) on the basis of the available information, the PR attempts to speak with the treating practitioner to obtain additional or clarifying information. If the PR 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”.
- PR pended review requests: If the treating practitioner is not available when the eQHealth dentist calls, the PR may issue a pend determination at that time. The particular information required is documented in the review record. The provider receives an electronic notification of the pended review.
  - The information must be provided within five business days.
  - If the requested information is not received within five 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 treating practitioner.

There are two types of adverse determinations: denial and partial denial.

Denial

The dentist peer 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 may 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 also are mailed to the treating provider and to the recipient or the recipient’s parent or legal guardian.
The written notification includes information about the provider’s and the 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 dentist peer 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.

For partial denials:

- 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 PA number as previously described for approval determinations.

**Reconsideration Reviews**

The provider and recipient or parent or legal guardian may request a reconsideration of an adverse determination. The only exception is when the provider expresses agreement with the adverse determination. In that case the right to reconsideration is waived. 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.
- Requests may be submitted through eQSuite™ or by fax, phone or mail. (See Section I: Accessibility and Contact Information - Requesting a Reconsideration of a Medical Necessity Denial.)
- The requesting party should submit additional or clarifying information.

**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 dentist 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 peer reviewer who was not involved in the original determination.

**Conducting the Review**

Date: November 15, 2012  Effective: December 1, 2012
The PR 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 services, units and duration.
- 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 receives 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 eQHealth’s receipt of a valid and complete request. Notifications are issued to the 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.
<table>
<thead>
<tr>
<th>Term</th>
<th>Acronym or Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse (in the context of “fraud and abuse”)</td>
<td></td>
<td>Section 409.913(1)(a), Florida Statute (F.S.) defines <em>abuse</em> as: Provider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care. (Also see “Fraud.”)</td>
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<tr>
<td>Admission review (also referred to as initial review)</td>
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<td>The first review by eQHealth Solutions (eQHealth) of administrative and clinical information submitted by providers requesting service authorization. The purpose of the review is to substantiate: 1. Compliance with all applicable Medicaid policies, and 2. The medical necessity of the service(s) for which authorization is requested. For dental services requiring review by eQHealth, the admission (initial) review request should be submitted at least 10 business days before the date of service. The only exception is when Medicaid eligibility is determined retroactively. In this situation submit the request as soon as retroactive eligibility is confirmed and within one year of the retroactive Medicaid eligibility determination date. Also see “Prior authorization”, “Retrospective review” and “Post-authorization request”.</td>
</tr>
<tr>
<td>Adult dental services</td>
<td></td>
<td>As explained in the Florida Medicaid Dental Services Coverage and Limitations Handbook, the adult Medicaid dental services program provides medically-necessary, emergency dental procedures to alleviate pain or infection to eligible Medicaid recipients age 21 and older. Emergency dental care for recipients 21 years of age and older is limited to a problem focused oral evaluation, necessary radiographs in order to make a diagnosis, extractions, and incision and drainage of an abscess. Full and removable partial dentures and denture-related services are also covered services of the adult dental program. Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for detailed coverage and limitations information.</td>
</tr>
<tr>
<td>Adverse determination (as it relates to utilization management findings)</td>
<td></td>
<td>A general term for any unfavorable medical necessity or appropriateness finding resulting from a physician’s review of the health care services for which authorization (approval) is requested. An adverse determination may be a (full) denial of the medical necessity of inpatient or non-inpatient services or a partial denial. Partial denials result in a reduction of covered services. 1. Denial: All planned services and the associated length of stay are found to be not medically necessary or appropriate. 2. Partial denial: This is a finding that a portion of the services are medically unnecessary or inappropriate.</td>
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<td>Term</td>
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<td>is not medically necessary or appropriate. Some of the services are approved and some are denied. For example, the partial denial may be associated with the number of units of service and/or the duration of services. Providers and recipients may request a reconsideration of an adverse determination. Also see “Non-certification” and “Reconsideration”.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency for Health Care Administration</td>
<td>Agency or AHCA</td>
<td>The agency is the Medicaid agency for the state, as provided under federal law.</td>
</tr>
<tr>
<td>Approval (as it relates to a prior authorization or utilization review determination)</td>
<td></td>
<td>See “Certification determination”</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>CMS</td>
<td>The federal agency within the United States Department of Health and Human Services (HHA) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards.</td>
</tr>
<tr>
<td>Certification determination or certified services</td>
<td></td>
<td>The prior authorization or utilization review finding that health care services are medically necessary and appropriate. (See “Utilization review”.) This determination also is referred to as an approval and is rendered by a physician, dentist or by a 1st level reviewer supported by decision support tools which may include clinical criteria, guidelines or algorithms.</td>
</tr>
<tr>
<td>Children’s dental services</td>
<td></td>
<td>As explained in the Florida Medicaid Dental Services Coverage and Limitations Handbook, the children’s dental program provides full dental services for all Medicaid eligible children age 20 and below. Refer to the Florida Medicaid Dental Services Coverage and Limitations Handbook for detailed coverage and limitations information.</td>
</tr>
<tr>
<td>Clinical reviewer</td>
<td></td>
<td>See “First level reviewer”.</td>
</tr>
<tr>
<td>Clinically unproven procedures</td>
<td></td>
<td>See “Experimental or clinically unproven procedures”.</td>
</tr>
<tr>
<td>Criteria (clinical)</td>
<td></td>
<td>In the context of prior authorization, utilization review, or utilization management, the National Committee for Quality Assurance (NCQA) defines criteria as “Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific health care decisions, services and outcomes.” Among other tools, eQHealth’s 1st level reviewers apply Agency-approved criteria to assist them in determining the medical necessity of particular health care services. If the criteria are</td>
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<td>satisfied, the reviewer may certify</td>
<td></td>
<td>(approve) the medical necessity of the services. If the criteria are not satisfied, the review request is referred to a physician or dentist (2nd level reviewer), to make the medical necessity determination.</td>
</tr>
<tr>
<td>Current Dental Terminology ©</td>
<td>CDT ©</td>
<td>Copyrighted service descriptions and codes used in the Florida Medicaid dental services program. The nomenclature is from the Current Dental Terminology (CDT) ©. CDT© (including procedure codes and descriptions) is copyrighted by the American Dental Association © 2008 American Dental Association. All rights reserved.</td>
</tr>
<tr>
<td>Denial</td>
<td></td>
<td>See &quot;Non-certification determination&quot; and &quot;Adverse determination&quot;.</td>
</tr>
<tr>
<td>Per Chapter 59G-1.010, Florida Administrative Code (F.A.C.) dentist means an individual who holds a valid and active license to practice dentistry or dental surgery in full force and effect pursuant to the provisions of Chapter 466, F.S., or the applicable laws of the state in which the service is furnished.</td>
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<tr>
<td>Dually-eligible recipient</td>
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<td>An individual who is eligible for both Medicaid and Medicare benefits.</td>
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</table>
| Per Chapter 59G-1.010, F.A.C. experimental, or experimental and clinically unproven, or investigational as related to drugs, devices, medical treatments or procedures means: (a) 1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; or 2. Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 3. Reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis. 4. The drug or device is used for a purpose that is not approved by the FDA. (b) Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written
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<tr>
<td>informed consent used by the treating</td>
<td></td>
<td>facility or by another facility studying substantially the same drug, device or medical treatment or procedure.</td>
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</table>
| Fair Hearing                             |                         | Per Chapter 59G-1.010, F.A.C., *Fair Hearing* means the opportunity afforded any Medicaid applicant or recipient, for whom there has been a determination to deny, reduce or terminate benefits or services, except when the determination is due solely to a law or policy requiring an automatic change, to have one or more impartial officials who have not been directly or indirectly involved in the initial determination of the action in question render a final decision based on information submitted for review pursuant to the hearing standards contained in federal regulations. Recipients (or their legal representatives) whose services are denied, suspended, terminated or reduced by AHCA may appeal the adverse decision. Such an adverse determination includes one that results from a medical necessity denial rendered by eQHealth Solutions. The Agency does not grant a hearing if:  
  ▶ The sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients, or  
  ▶ The adverse determination is a result of the recipient’s physician’s order.  
The appeal is requested through a written statement. The Agency then must grant an opportunity for a hearing to any recipient, or a recipient’s parent or legal guardian, if the Agency (or eQHealth Solutions when conducting review) denies, terminates, suspends or reduces services. eQHealth includes the hearing notice with its notice of adverse determination mailed to the recipient or the recipient’s authorized representative. The appeal request may be made no later than 90 calendar days from the date the hearing notice is mailed. |
| First level determination                | 1st level determination | A prior authorization or review decision rendered by a 1st level reviewer. (See “First Level Reviewer”.) A 1st level determination is one of the following:  
  ▶ Certification of services  
  ▶ Referral to a physician or dentist reviewer  
  ▶ Pend: a determination that additional information is needed and requesting the information from the provider  
  ▶ Cancellation of the authorization request due to AHCA administrative policy rules |
| First level reviewer (also referred to as | 1st level reviewer      | An eQHealth Solutions employee or contractor who maintains an active Florida license as applicable for his clinical profession and who meets all other AHCA-defined credentials required to |
### Appendix A - Definitions

**Term** | **Acronym or Abbreviation** | **Definition**
--- | --- | ---
clinical reviewer) | | perform utilization management services and to render medical necessity certifications (approvals). The term includes the licensed professionals who directly or indirectly supervise the staff or contractors and who themselves may perform utilization management services.

As applicable for the service under review and as approved by the Agency, eQHealth’s 1st level reviewers include:

- Dental hygienists.
- Registered nurses.
- Physical therapists.
- Occupational therapists.
- Speech-language pathologists.

In performing their work, 1st level reviewers rely on a variety of clinical decision support tools including criteria and guidelines. They cannot render adverse determinations. Only a 2nd level reviewer (physician or dentist) may do that.

Fiscal agent | FA | A private corporation under contract with AHCA to receive and process Medicaid claims.

Fiscal year | | A budgetary, financial reporting or cost accounting time period, 12 months in length. The state of Florida’s fiscal year is July 1 through June 30.

Florida Medicaid Management Information System | FMMIS or MMIS | “Florida Medicaid Management Information System (FMMIS)” means the computer system used to process Florida Medicaid claims and to produce management information relating to the Florida Medicaid program. (Per Chapter 59G-1.010, F.A.C.) Florida’s computer system that contains provider and recipient records and eligibility data.

Fraud (in the context of “fraud and abuse”) | | Per Chapter 59G-1.010, F.A.C. fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (Also see “Abuse”.)

Guidelines (clinical) | | The U.S. Dept. of Health and Human Services’ National Heart Lung and Blood Institute (NHLBI) 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
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<td>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)</td>
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<td>Compare with “Criteria (clinical)”.</td>
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<tr>
<td>Handicapping malocclusion</td>
<td>As explained in the Florida Medicaid Dental Services Coverage and Limitations Handbook, orthodontic services are limited to recipients with the most handicapping malocclusion. <em>A handicapping malocclusion</em> is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility of dental caries, and impaired speech due to malpositions of the teeth.</td>
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<td>Health Insurance Portability and Accountability Act (of 1996)</td>
<td>HIPAA</td>
<td>The Act includes three major Rules: 1) Administrative Simplification (AS); 2) Security; 3) Privacy. The AS provisions require national standards for electronic health care transactions and national identifiers for providers, health plans and employers. (Also see “National Provider Identifier”.)</td>
</tr>
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| Initial Assessment Form | IAF | The Medicaid Orthodontic Initial Assessment Form (IAF) (AHCA-Med Serv Form 013) is completed by an orthodontic provider at the initial evaluation of the recipient. The IAF is:  
- Designed for use as a guide by the provider to determine whether a PA request should be submitted; and  
- A means by which the orthodontic provider may communicate to Medicaid’s orthodontic consultant all the distinctive details pertaining to an individual case. Detailed information about completing and using the IAF is included in the Florida Medicaid Dental Services Coverage and Limitations Handbook. The form may be downloaded from our Web site http://fl.eqhs.org. It also is available at www.mymedicaid-florida.com. Select Public Information for Providers, the Provider Support and then Forms. |
<p>| Initial review (also referred to as admission review) | See “Admission review”. |
| International Classification of Diseases coding system | ICD-9-CM | “ICD-9-CM Diagnosis and Procedure Codes” means the International Classification of Diseases, 9th 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. |
| Medicaid Identification | MIC | A temporary proof of Medicaid eligibility that the recipient may |</p>
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<th>Definition</th>
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<td>Card</td>
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<td>use until he receives his Medicaid gold card. It is also referred to as an AMIC.</td>
</tr>
<tr>
<td>Medicaid Provider Access System and Program</td>
<td>MediPass</td>
<td>“Medicaid Physician Access System (MediPass)” means the physician primary care case management waiver program. A primary care, case management program designed to assure Medicaid recipients access to care, decrease inappropriate service utilization, and control costs. The program is available statewide. MediPass primary care providers are responsible for providing or arranging for the recipient’s primary care and for referring the recipient for other necessary medical services.</td>
</tr>
<tr>
<td>Medically necessary or medical necessity</td>
<td></td>
<td>Per Chapter 59G-1.010, F.A.C <em>medically necessary or medical necessity</em> means that the medical or allied care, goods, or services furnished or ordered must meet the following conditions:</td>
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<td>▶ Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;</td>
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<td>▶ Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;</td>
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<td></td>
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<td>▶ Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;</td>
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<td>▶ Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and</td>
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<td></td>
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<td>▶ Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.</td>
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<td></td>
<td></td>
<td>The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, good or services medically necessary or a medically necessity or a covered service.</td>
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<td></td>
<td></td>
<td>Also see “Service criteria”.</td>
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<tr>
<td>Medically Needy Program</td>
<td></td>
<td>The Florida Medicaid Provider General Handbook (Chapter 3) provides the following description of the Medically Needy Program: “A Medically Needy recipient is an individual who would qualify for Medicaid, except that the individual's income or resources exceed Medicaid’s income or resource limits. On a month-by-month basis, the individual's medical expenses are subtracted from his income. If the remainder falls below Medicaid’s income limits, the individual may qualify for Medicaid for the day he became eligible until the end of the month.”</td>
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<td>Term</td>
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<tr>
<td>Modification review</td>
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<td>This type of review is applicable only for orthodontic services. It is the review type when an extension of the previously approved maximum 24 service units (visits) is needed within the current authorization period. The request must be submitted as soon as the need for additional units is identified, before additional visits are incurred and before expiration of the current authorization period.</td>
</tr>
<tr>
<td>National Provider Identifier</td>
<td>NPI</td>
<td>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.</td>
</tr>
<tr>
<td>Non-certification</td>
<td></td>
<td>A prior authorization or review determination rendered by a physician or dentist (2nd level reviewer) when health care services are not medically necessary or appropriate. That is, based on the available clinical information, the 2nd level reviewer cannot certify (attest to) the medical necessity or appropriateness of the services. Also referred to as a medical necessity denial, this adverse determination may only be rendered by a 2nd level reviewer. (Also see “Adverse determination”.)</td>
</tr>
<tr>
<td>Oral And Maxillofacial Surgery Program</td>
<td></td>
<td>As explained in the Florida Medicaid Dental Services Coverage and Limitations Handbook, the oral and maxillofacial surgery program provides medically necessary coverage for all eligible Medicaid recipients regardless of age.</td>
</tr>
<tr>
<td>Partial denial (as it relates to utilization management findings)</td>
<td></td>
<td>See “Adverse determination”.</td>
</tr>
<tr>
<td>Partial dentures</td>
<td></td>
<td>As discussed in the Florida Medicaid Dental Services Coverage and Limitations Handbook, partial dentures refer to the prosthetic appliance that replaces missing teeth and is on a framework that is removed by the patient.</td>
</tr>
<tr>
<td>Pend (or pended) review</td>
<td></td>
<td>The status of a review request when additional clinical information is needed to complete the review. eQHealth informs the provider that the review request is pended for additional information. For dental services the provider is asked to submit the information within five business days. (Also see “Suspended Review”.)</td>
</tr>
<tr>
<td>Prior authorization</td>
<td>PA</td>
<td>A request submitted to the fiscal agent (FA), Medicaid or a</td>
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Date: November 15, 2012
Effective: December 1, 2012
Proprietary
Definitions
Page 24 of 28
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<th>Term</th>
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<td>quality improvement organization (QIO) for approval to deliver Medicaid covered medical or allied care, goods, or services. Periodontic and orthodontic services requiring prior authorization by eQHealth Solutions are identified in the Dental General Fee Schedule. They have a &quot;Y&quot; in the &quot;PA&quot; column.</td>
<td>PHI</td>
<td>Information created or received from or on behalf of a HIPAA-defined Covered Entity as defined in 45 CFR 160.103 which include provisions for strictly safeguarding the confidential nature of an individual’s information. PHI includes not only an individual’s medical/clinical information but also demographic information that identifies the individual or about which there is a reasonable basis to believe, can be used to identify the individual.</td>
</tr>
<tr>
<td>Provider</td>
<td>PSN</td>
<td>Per Chapter 59G-1.010, F. A. C., provider means a person or entity that has been approved for enrollment and has a Medicaid provider agreement contract in effect with the department. It is a general term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills for Medicaid services.</td>
</tr>
<tr>
<td>Provider Service Network</td>
<td>QIO</td>
<td>An integrated health care delivery system owned and operated by Florida hospitals and physician groups. It is a Medicaid managed care option for recipients residing in certain geographic regions of the State.</td>
</tr>
<tr>
<td>Quality Improvement Organization</td>
<td>QIO</td>
<td>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.”</td>
</tr>
<tr>
<td>Recipient</td>
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<td>“Recipient” or “Medicaid recipient” means any individual whom the Agency, Department of Children and Family Services or the Social Security Administration on behalf of the Department of Children and Family Services determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services.</td>
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<td>services for which the Agency</td>
<td></td>
<td>may make payments under the Medicaid program and is enrolled in the Medicaid program. (Per Chapter 59G-1.010, F. A. C.)</td>
</tr>
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| Reconsideration                  |                         | A second review of health care services for which an adverse determination was rendered by a physician or dentist and which is performed by a physician or dentist who was not involved in the original determination. For dental services it may be requested by the treating provider and/or the recipient (or parent or legal representative). The outcome of a reconsideration may be one of the following:  
  - Modified - Some of the services are certified (approved) and some continue to be non-certified (denied).  
  - Reversed – Services are certified (approved) as originally submitted. The original determination is over-turned.  
  - Upheld – The original non-certification (denial) is maintained. |
<p>| Removable prosthodontics         |                         | As explained in the Florida Medicaid Dental Services Coverage and Limitations Handbook, removable prosthodontics involves the fabrication, repairing, relining and adjusting of an appliance for the replacement of extracted teeth, by and under the direction of a dentist. This appliance is removed from the mouth by the patient. |
| Retrospective review             |                         | Utilization review performed after health care services have been completed or were otherwise concluded. For dental services this type of review is applicable only for recipients who are retroactively eligible for Medicaid and who are no longer receiving services. The authorization request should be submitted as soon as eligibility is confirmed and within one year of the retroactive eligibility determination date. |
| Second level reviewer            | 2nd level reviewer      | A Florida-licensed physician or dentist who meets all physician or dentist reviewer credentialing requirements established by AHCA and who is employed or contracted by eQHealth Solutions to perform utilization management services. The term includes individual physicians and dentists as well as the physicians or dentists who directly or indirectly supervise them and who themselves may perform utilization management services. Only a 2nd level reviewer may render an adverse determination. (Also see &quot;First level reviewer&quot; and &quot;Adverse determination&quot;). |
| Service authorization            |                         | Per Chapter 59G-1.010, F. A. C., service authorization means the approval required from the designated authority for reimbursement for certain Medicaid services.                                                                                                                                                             |
| Service criteria or service      |                         | requirements                                                                                                                                                                                                                                                                                                                               |
|                                  |                         | As stated in the Florida Medicaid Dental Services Coverage and Limitations Handbook, for services to be eligible for reimbursement under the Adult and Children's Dental Program, the services must be medically necessary and may not duplicate another provider's service. In addition, the services must meet |</p>
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<td>the following criteria:</td>
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<td>The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;</td>
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<td>The services cannot be experimental or investigational;</td>
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<td>The services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and</td>
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<td>The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.</td>
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<td>The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a covered service. Also see “Medically necessary or medical necessity” and “Experimental or clinically unproven procedures.”</td>
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<tr>
<td>Service limit or limitation</td>
<td>Per Chapter 59G-10.01, F. A. C. service limit or service limitation means the maximum amount, duration, or scope of a Medicaid covered service. Service limits and limitations are specified in the applicable Florida Medicaid Provider Handbook.</td>
<td></td>
</tr>
<tr>
<td>Share of cost</td>
<td>The amount of medical expenses that must be deducted from an enrolled Medically-Needy recipient's income to make him eligible for Medicaid.</td>
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<td>Supporting documentation</td>
<td>Supporting documentation is particular documentation required at the time of an authorization request for particular services such as dental procedures, durable medical equipment home health services and physical therapy. The nature of the required documentation varies according to the type of service and may vary according to the type of authorization request.</td>
<td></td>
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<td>Suspended review</td>
<td>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”.)</td>
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<tr>
<td>Third party liability</td>
<td>See “Third party liability.”</td>
<td></td>
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<tr>
<td>Third party liability</td>
<td>TPL</td>
<td>Per Chapter 59G-1.010, F. A. C., third party means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical</td>
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<tr>
<td>services related to any medical assistance covered by Medicaid.</td>
<td></td>
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</tr>
<tr>
<td>Title XIX</td>
<td></td>
<td>“Title XIX” means the sections of the federal Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations there under, that authorizes the Medicaid program. (Per Chapter 59G-1.010, F. A. C.).</td>
</tr>
</tbody>
</table>