**Introduction:** eQHealth Solutions’ Mississippi Youth Programs Around the Clock (MYPAC) Services Utilization Management Program includes prior authorization of specific MYPAC services for Mississippi Medicaid beneficiaries in defined eligibility categories; who are not enrolled in the Mississippi Coordinated Access Network. This manual should be used as a companion to the Mississippi Administrative Code and the Medicaid fee schedule.

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

Did you check beneficiary eligibility?

The plastic Medicaid card is not a guarantee of Medicaid eligibility. You must access the beneficiary’s eligibility and service limit information through the eligibility verification options before submitting a prior authorization request to eQHealth Solutions.

You are responsible for verifying a Medicaid beneficiary’s eligibility each time the beneficiary appears for service. You are also responsible for confirming the person presenting the card is the person to whom the card is issued.

You can verify eligibility by the Medicaid ID number or Social Security number of the beneficiary to access either of the following services:

- Website verification:
  o [https://www.ms-medicaid.com/msenvision/](https://www.ms-medicaid.com/msenvision/)

- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/Beneficiary Services Call Center at 1-800-884-3222
- Medicaid Eligibility Verification Services (MEVS) transaction using personal computer (PC) software or point of service (POS) swipe card verification device.

**Medicaid Coverage – Categories of Eligibility (COE)**
eQHealth Solutions’ MYPAC utilization management services are applicable for Mississippi Medicaid beneficiaries in the following eligibility categories:

- Fee-for-service, including those who have third party coverage
- Dual coverage, private insurance and Medicaid

Please check eligibility at each visit.
MYPAC Review Exclusions

Medicaid policy exempts certain encounters from eQHealth review and the provider should not submit review requests for these situations.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Medicaid Eligibility</td>
<td>If the beneficiary is not Medicaid eligible, or has applied for Medicaid and the eligibility determination is pending, no eQHealth review is required.</td>
</tr>
<tr>
<td>Medicare Eligibility</td>
<td>No review is allowed if the beneficiary has Medicare Part A and Part B coverage for the encounter timeframe and the Medicare benefits are not exhausted.</td>
</tr>
<tr>
<td>Non-Eligible EPDST Beneficiaries</td>
<td>MYPAC services are not available for non-eligible EPSDT beneficiaries.</td>
</tr>
<tr>
<td>Duplication of Services</td>
<td>No review is allowed if a review determination has already been rendered for the requested services for a different provider.</td>
</tr>
<tr>
<td>Family Planning Waiver</td>
<td>No review is required if the beneficiary’s Medicaid eligibility is only for the family planning waiver.</td>
</tr>
</tbody>
</table>

Certification should be obtained when the beneficiary:

- Has Medicare Part A and Part B and benefits are exhausted and the beneficiary has private insurance.
- Has Medicaid eligibility and third party insurance.
Providers must read and be familiar with DOM's rules and procedures located at https://medicaid.ms.gov/providers/administrative-code/. Request for treatment authorizations are submitted to eQHealth when the eligibility requirements detailed in Mississippi Administrative Code, Title 23 Medicaid, Part 206 Mental Health, Chapter 2 Mississippi Youth Program Around the Clock (MYPAC) Rule 2.2 are met.

**MYPAC Service Codes Requiring Precertification**

MYPAC providers must pre-certiﬁy services through eQHealth. Service codes, narrative descriptions and maximum units/days are listed in the following table.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Descriptions</th>
<th>Units/Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2022</td>
<td>Community Based Wraparound</td>
<td>115 Units/365 Days</td>
</tr>
</tbody>
</table>
Section II – Submitting your prior authorization request:

How to submit your request
Reviews are submitted electronically using eQHealth’s proprietary Web-based software, eQSuite®.

eQSuite’s® Key Features Include:
- Secure HIPAA-compliant technology allows you to electronically record and transmit most information necessary for a review to be completed.
- Secure transmission protocols including the encryption of all data transferred.
- System access control for changing or adding authorized users.
- 24x7 access with easy to follow data entry screens.
- Rules-driven functionality and system edits which assist you by immediately alerting them to such things as situations for which review is not required.
- A reporting module that provides the real time status of all review requests.
- A HELPLINE module through which providers may submit questions about a specific PA request.

Minimal System Requirements
- Computer with Intel Pentium 4 or higher CPU and monitor
- Windows XP SP2 or higher
- 1 GB free hard drive space
- 512 MB memory
- Internet Explorer 8 or higher, Mozilla Firefox 3 or higher, or Safari 4 or higher
- Broadband internet connection

eQHealth will provide information explaining everything you need to know to access eQSuite®. To get started, you will designate a system administrator, and eQHealth will assign a user ID and password for him or her. The administrator does not need to be an information systems specialist; however, this person will be responsible for your
organization/offices’ user IDs and passwords. Managing system access is a user-friendly, non-technical process.

**Types of Review Requests**

A review for initiation of a service (s) is referred to as an admission review. Subsequent reviews are performed to determine if continuation of services is medically indicated and appropriate. These are called continued stay reviews.

Community based wrap-around services are reviewed for medical necessity and appropriateness.

The following table describes the types of review, timeframes for submission, and required documentation for each type of review. Forms are available on our website [http://ms.eqhs.org](http://ms.eqhs.org) for emergency use in the event of internet outages.

<table>
<thead>
<tr>
<th>Review Type</th>
<th>Timeframe</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preadmission Review</td>
<td>At least 3 (three) business days prior to initiation of MYPAC services.</td>
<td>Use eQSuite® to submit the admission request or fax/mail a completed MYPAC Admission Certification Request Form.</td>
</tr>
<tr>
<td></td>
<td><em>For extenuating circumstances contact eQHealth Solutions.</em></td>
<td>The following documents should be uploaded via eQSuite® or faxed with the MYPAC Admission Certification Request Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A copy of the psychiatric evaluation which must be performed by a psychiatrist or a licensed psychologist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A pre-discharge recommendation in lieu of the evaluation if the youth is in an acute care or PRTF setting prior to beginning MYPAC.</td>
</tr>
<tr>
<td>Review Type</td>
<td>Timeframe</td>
<td>Required Documentation</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Continued Stay/Recertification request:</td>
<td>At least 30 (thirty) days prior to the last date certified.</td>
<td>Use eQSuite® to submit the continued stay request or fax/mail a completed MYPAC Continued Stay Request Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following documents should be uploaded via eQSuite® or faxed with the MYPAC Continued Stay Certification Request Form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A copy of the most current Individualized Service Plan indicating the necessity of continuing the current level of care. Plan should be dated no more than 30 days from the date of the request.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A copy of the Child and Family Team Meeting Notes for the past two meetings, one of which must be within the last 30 days.</td>
</tr>
</tbody>
</table>

eQSuite® guides you through the request submission process. However in this section we explain the prior authorization review process for MYPAC services.
Section III – What eQHealth looks for when reviewing your request

The eQHealth Review Team, who we are:
eQHealth is a multidisciplinary team, composed of registered nurses, physicians and physician consultants. The MYPAC review team is overseen by our Medical Director.

Automated Administrative Screening
When the review request is entered in eQSuite® the system applies a series of edits to ensure authorization by eQHealth is required and that all Medicaid eligibility requirements, Administrative Code and policies are satisfied. If there is an eligibility issue or the services are not subject to review, the system will inform and prompt the user to cancel the review.

Clinical Reviewer (1st Level) Screening of the Request
When there are no review exclusions identified by eQSuite® the system routes the request to a first level reviewer who screens and reviews the request. The first level reviewer evaluates the entire request for compliance with Administrative Code that cannot be applied by the automated process and for compliance with supporting documentation requirements.

Screening for Compliance with Administrative Code
If the first level reviewer identifies an issue with the request related to Medicaid requirements, a technical determination (TD) is rendered and your review will not proceed. The requesting provider is notified electronically through eQSuite®, and by phone call. Since a technical determination is rendered for an administrative reason (not a clinical or medical necessity reason) it is not subject to reconsideration.

If all required information is not received with the request, the first level reviewer “pends” the request. You will be notified electronically and by phone call. The information must be received within one (1) business day. If it is not received within the specified time frame the review request is suspended and you will be notified electronically. If the information is submitted at a later date eQHealth will re-open the review and the review
will be performed for services from the date the information was received. eQHealth cannot backdate the request.

**Clinical Information Screening and Pended and Suspended Requests**

**Clinical Information Screening**

Before performing the medical necessity review, the first level reviewer screens the submitted clinical information for completeness to do 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:

- You will receive a phone call and you can access the review record to determine what additional information is needed.
- The requested information must be submitted within one (1) business day.
- If eQHealth does not receive the information within one (1) business day, the review request is suspended and no further review processing occurs until the additional information requested has been received. You are notified by phone and electronically, the request is suspended. If the information is submitted at a later date, eQHealth re-opens the request and reviews the services beginning from the date the complete information was received. eQHealth cannot backdate the request.

**First Level Medical Necessity Review Process**

When all information has been submitted and the clinical information screening is completed, the first level reviewer performs the medical necessity review. When performing the review, the first level reviewer evaluates all clinical information recorded in eQSuite® and all submitted information.

**Clinical Criteria for MYPAC Services**

eQHealth Solutions first level reviewers uses Administrative Code, DOM regulations and rules as well Interqual® as tools when making clinical determinations concerning the medical necessity of care.
Approvals
First level reviewers apply Medicaid approved clinical guidelines to determine whether the services are medically necessary or otherwise allowable under Medicaid policy. If the criteria are satisfied, the clinical reviewer renders an approval determination for each line item, for the number of units requested and for the requested time frame or policy maximum.

Approval Notifications
Approval notifications are generated for all services determined to be medically necessary. Electronic notifications are generated to the 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.
- Within one (1) business day of the determination eQHealth posts a provider notification letter. The notification specifies the authorized service(s), the number of units, the authorization period, and the Treatment Authorization Number (TAN). You may access the notification by logging onto eQSuite®. The notifications may be downloaded and printed.
- eQHealth transmits the Treatment Authorization Number (TAN) to the Medicaid fiscal agent.

Referral to a Second Level Reviewer (SLR)
First level reviewers may not render an adverse determination; any requests which they cannot approve are referred to a SLR. When the first level reviewer refers a review request to a SLR the requesting provider’s Web-based status report is updated and displays the referral status.

Second Level (Physician) Review Process
The SLR uses clinical experience, knowledge of generally accepted professional standards of care and judgment.
Approval Determinations and Pended Reviews
For each service the first level reviewer was unable to approve, the SLR determines the medical necessity of the service and the number of units and service duration requested.

- **Approval on the basis of available information**: When the available information substantiates the medical necessity of the service(s), units and service duration, the SLR approves them as requested and the review is completed. Notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.

- **You may receive a pend if additional information is required**: If a SLR is not able to approve the service(s) on the basis of the available information, the SLR may attempt to speak with the treating practitioner to obtain additional or clarifying information. If the treating practitioner is not available when the SLR calls, the SLR may issue a pend determination at that time. Any information obtained telephonically or via pend is documented in the review record. If the SLR is able to authorize the service(s) on the basis of the additional or clarifying information obtained, an approval determination is rendered. The review is complete and notifications are issued as described under “First Level Medical Necessity Review Process: Approval Notifications”.

- **SLR pended review requests**. You will receive an electronic notification of the pended review.
  - The information must be provided within three (3) business days.
  - If the requested information is not received within three (3) business days, the SLR renders a determination on the basis of the information that is available.

Adverse Determinations
Only a SLR may render an adverse determination (denial). As noted in the preceding section, prior to rendering an adverse determination the SLR may attempt to discuss the request with the treating practitioner. There are two types of adverse determinations: denial and partial denial.
**Denial**
The SLR may render a (full) medical necessity denial of one or more line items.

- You will receive an immediate electronic notification, via the eQSuite® review status report, of the denial. eQHealth will also phone when there is a denial decision.
- Within two (2) business days of the determination, the final written notification of the denial is posted electronically for you in eQSuite®. The notification may be downloaded and printed.
- Written denial notifications also are mailed to you and to the beneficiary, the beneficiary’s parent, or legal guardian/caretaker.
- The written notification includes information about your rights and the beneficiary’s right to a reconsideration of the adverse determination.
- The beneficiary’s notification also includes information about his/her right to request an appeal.

The eQHealth Medical Director or in their absence, their designee is available to speak with you to explain clinical denials.

**Reconsideration Reviews**
You, the beneficiary, or parent/guardian/caretaker may request a reconsideration of an adverse determination. Adverse determination notices contain instructions for requesting reconsideration: The reconsideration must be requested within 30 calendar days of the date of the denial notification. Additional information may be found in our [Reconsideration Manual](#).
Section IV – IF YOU NEED INFORMATION OR ASSISTANCE

We offer a variety of ways for you to obtain information or assistance you need when submitting prior authorization (PA or review) requests. In the following sections we identify, by topic or type of assistance needed, useful resources.

Questions about the MYPAC Services Utilization Management Program
For questions or information about the MYPAC Services Utilization Management Program, the following resources are available:
  - eQHealth MYPAC Services Provider Manual.
  - Training presentations: Copies of training and education presentations are available under the “Education” tab.
- eQHealth’s HELPLINE Toll free number 1-866-740-2221.

Questions about Using our Web-based Review System
eQSuite® is our proprietary Web-based review system. It is used to submit PA requests for MYPAC Services. The eQSuite® User’s Guide is available on our Web site: http://ms.eqhs.org.

Submitting Prior Authorization Requests by Means Other than Web
If you do not use computers in day-to-day operations, please contact eQHealth’s HELPLINE Toll free number 1-866-740-2221.

How to submit documentation when needed or requested
To submit documentation to an existing request created in eQSuite® there are two methods you can follow:
- Upload and directly link the information to the eQSuite® review record.
- Download eQHealth’s fax cover sheet(s) and submit the information using our 24 x 7 accessible toll-free fax number: 1-888-204-0377.

If you choose to fax the documentation, we provide downloadable special fax cover sheets. Each fax cover sheet includes a bar code that is specific to the review and for the type of required information. The review fax cover sheets are available for download and printing as soon as the review request is completely entered in eQSuite® and submitted for review.
Checking the Status of a PA Request or Submitting an Inquiry about a Request

To determine the status of a previously submitted PA request, use your secure eQSuite® login and check the information in your review status report. If you have additional questions about a previously submitted PA request, submit an inquiry using eQSuite’s® HELPLINE module. Both options are available 24 hours a day. Although using eQSuite® is the most efficient way to obtain information about PA requests, you also may call our HELPLINE Toll free number 1-866-740-2221.

eQHealth Solutions HELPLINE

For general inquiries, or questions that cannot be addressed through eQSuite® or if you have a complaint, or a compliment, contact our HELPLINE Toll free number 1-866-740-2221 available 8:00AM – 5:00PM Central Time, Monday through Friday.

If you call during non-business hours, you have the option of leaving a message.

If you have a complaint or compliment and would prefer to write to us, there are two options. Fax the information to our toll free Quality Concerns fax number: 1-888-204-0221 or mail the information to:

eQHealth Solutions - Mississippi Division
Attention: Quality Concerns
460 Briarwood Drive, Suite #300
Jackson, MS 39206
Discharge and Readmission Process

When a beneficiary is discharged from MYPAC services for any reason the provider should use the discharge utility function in eQSuite® to enter the discharge date. **Do not fax discharge forms to eQHealth Solutions.** There are specific conditions when readmission into MYPAC is appropriate. Please review the following grid for readmission specifications.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Discharge Timeframe</th>
<th>Readmission Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged from MYPAC service due to admission to acute psychiatric or PRTF services.</td>
<td>Discharge from MYPAC was more than 29 consecutive calendar days.</td>
<td>A new admission review must be submitted.</td>
</tr>
<tr>
<td>Discharged from MYPAC service due to admission to acute psychiatric or PRTF services.</td>
<td>Discharge from MYPAC was 29 consecutive calendar days or less, <strong>AND</strong> readmission is requested <strong>within</strong> 90 calendar days of the initial certification begin date.</td>
<td>If readmission to MYPAC is clinically needed, the Treatment Authorization Number (TAN) can be administratively re-opened. To request, submit an Online Helpline request or call the Helpline at 866-740-2221 and provide the following information. • Treatment Authorization number. • The readmission date into MYPAC services. The end date of the original TAN will remain the same. eQHealth will evaluate the change request according to the discharge timeframe criteria outlined in the left column. eQHealth will notify providers of TAN revisions via review outcome notification communications.</td>
</tr>
<tr>
<td>Condition</td>
<td>Discharge Timeframe</td>
<td>Readmission Process</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Discharged from MYPAC service due to admission to acute psychiatric or PRTF services.</td>
<td>Discharge timeframe was 29 consecutive days or less, <strong>AND</strong> readmission is requested 90 calendar days <em>after</em> initial certification begin date.</td>
<td>A new admission review must be submitted.</td>
</tr>
<tr>
<td>Discharged from MYPAC services program for any reason other than admission to acute psychiatric or PRTF services.</td>
<td>Not Applicable.</td>
<td>A new admission review must be submitted.</td>
</tr>
</tbody>
</table>
Quality Review Process
The Mississippi Division of Medicaid (DOM) requires review of the quality of care provided to Medicaid beneficiaries receiving MYPAC services. Quality of care review is conducted for all review types as well as through a randomly selected 5% quality sample of cases certified by eQHealth.

eQHealth identifies aberrant patterns and/or trends by provider. Quality sampling may include health care services provided to all age groups.

Please see the Quality Review Process Manual for additional details.
## SECTION V - DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Appeal</td>
<td>If the reconsideration outcome was to uphold the denial and there is a disagreement with this decision, the beneficiary/legal representative may request an administrative appeal from the Division of Medicaid</td>
</tr>
<tr>
<td>New Services/Admission Review</td>
<td>The review performed by eQHealth when a new or existing patient’s information is entered into the eQHealth web portal for the first time or is new to the precertification process. Admission Review is interchangeable with Precertification Review.</td>
</tr>
<tr>
<td>Bar Coded Fax Coversheet</td>
<td>Web utility option that allows the provider to print a specialized cover sheet encrypted with bar code technology that links required documents directly to a specific review. The coversheet is designed for one use and may not be altered in any way.</td>
</tr>
<tr>
<td>Denial</td>
<td>Occurs when requested services are not approved. Only a SLR can clinically deny a request.</td>
</tr>
<tr>
<td>Errors or Error Message</td>
<td>A eQSuites® message indicating the request is incorrect and can’t be submitted, (i.e. submitting a prior authorization request for a MSCAN enrolled beneficiary will cause an error and is displayed as such.)</td>
</tr>
</tbody>
</table>
### First Level Reviewers

<table>
<thead>
<tr>
<th>eQHealth first level reviewers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Apply DOM policy.</td>
</tr>
<tr>
<td>• Apply DOM approved medical necessity clinical guidelines.</td>
</tr>
<tr>
<td>• Request additional information.</td>
</tr>
<tr>
<td>• Refer requests that cannot be approved for review and determination by a second level reviewer.</td>
</tr>
<tr>
<td>• Authorize care.</td>
</tr>
</tbody>
</table>

### Guidelines (clinical)

The U.S. Dept. of Health and Human Services’ states that clinical guidelines “…define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients”. The purpose of guidelines is to support health care decision-making by “describing a range of generally accepted [treatment] approaches…” In contrast with strict criteria and prescriptive protocols, guidelines provide recommendations for management of particular diseases or conditions. When referencing guidelines, emphasis is placed on the importance of exercising sound, situation-specific clinical judgment. Recommendations contained in guidelines are based on findings that certain diagnostic or therapeutic practices have been found “to meet the needs of most patients in most circumstances”, [but clinical] “…judgment…remains paramount [in developing] treatment plans that are tailored to the specific needs and circumstances of the patient.” (NHLBI)

Compare with “Criteria (clinical)”
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Classification of Diseases coding system</td>
<td>“ICD-10-CM Diagnosis and Procedure Codes” means the International Classification of Diseases, 10th Revision, and Clinical Modification, which is a method of classifying written descriptions of diseases, injuries, conditions, and procedures using alphabetic and numeric designations or codes.</td>
</tr>
<tr>
<td>National Provider Identifier (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>Pend</td>
<td>Refers to the process of placing a review request on hold until additional information has been received. eQHealth will notify the provider of the information needed along with a time frame for submission</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>Process for receiving approval for services.</td>
</tr>
<tr>
<td>Quality Improvement Organization (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</td>
</tr>
<tr>
<td><strong>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.”</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Reconsideration</strong></td>
<td>Following a clinical denial either the beneficiary/legal representative, service provider and/or attending physician can request reconsideration or “another look” by an eQHealth SLR, (different from the initial SLR) to review the request and any additional information submitted.</td>
</tr>
<tr>
<td>Second Level Reviewers</td>
<td>eQHealth second level reviewers (SLR):</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Make certification, denial or reconsideration determinations. That decision is:</td>
</tr>
<tr>
<td></td>
<td>o Based on documentation that supports prognosis and medical appropriateness of setting.*</td>
</tr>
<tr>
<td></td>
<td>o Patient-centered and takes into consideration the unique factors associated with each patient care episode.</td>
</tr>
<tr>
<td></td>
<td>o Sensitive to the local healthcare delivery system infrastructure.</td>
</tr>
<tr>
<td></td>
<td>o Based on his or her clinical experience, judgment and accepted standards of healthcare.</td>
</tr>
<tr>
<td></td>
<td>- Request additional information.</td>
</tr>
<tr>
<td></td>
<td>- Clinically deny certification</td>
</tr>
</tbody>
</table>

**Only a SLR can clinically deny a request.**

The second level reviewer may contact the ordering physician or service provider to obtain additional information when the documentation submitted does not clearly support medical necessity.

<table>
<thead>
<tr>
<th>Supporting documentation</th>
<th>Supporting documentation is particular documentation required at the time of an authorization request for particular services.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The nature of the required documentation may vary according to the type of service and according to the type of authorization request.</td>
</tr>
<tr>
<td><strong>Suspended review</strong></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>
</tr>
<tr>
<td><strong>Treatment Authorization Number (TAN)</strong></td>
<td>The acronym for “Treatment Authorization Number” is the number issued by eQHealth following the review approval process.</td>
</tr>
<tr>
<td><strong>Upload</strong></td>
<td>Web utility option that allows required documents in a .tif, .jpeg, or pdf files to be directly linked from a computer to a specific review.</td>
</tr>
<tr>
<td><strong>Unsuspended review</strong></td>
<td>The status of a review request when a provider submits all additional clinical information that was needed to complete a review. When all required information is submitted, eQHealth “unsuspends” the review request and completes the review. (Also see “Suspended review” and “Pend (or pended)” review.)</td>
</tr>
</tbody>
</table>
Mississippi Youth Programs Around the Clock (MYPAC) Services Provider Manual – Mississippi Division

Effective: November 1, 2014
Revised: January 2017

Mississippi Youth Programs Around the Clock (MYPAC) Services Provider Manual – Mississippi Division

Request for Certification

Is Beneficiary EPSDT eligible?

Yes

Refer for Second Level (Physician) Review

No

First Level Reviewer requests if clinical information is complete.

Yes

Meets Clinical Guidelines?

Yes

Information received

No

Suspend Review *See Note below

Provider receives electronic/written notification

Second Level (Physician) Review

Information received

May contact rendering provider to ask for additional information

No

Provider receives outcome notification.

Yes

Data Entry of Determination, Item, Timeframe Assigned and Treatment Authorization Number (TAN) Assigned.

Treatment Authorization Number (TAN) Transmitted to fiscal agent (MMIS).

Note: eQHealth holds request indefinitely. If the provider has not responded within 45 business days, the request is suspended. This means the request remains pended waiting for the provider to complete deficits in the clinical information but is removed from active eQHealth work queues. However if appropriate the request may be reactivated by the requestor/provider and processed if appropriate.

Provider receives electronic/written notification which includes reconsideration instructions. Medicaid beneficiary receives written denial notice, and reconsideration instructions.

Provider receives electronic/written notification

Clinical determination by Second Level (Physician) Reviewer

Approved

Data Entry of Determination, Item, Timeframe Assigned and Treatment Authorization Number (TAN) assigned.

Provider receives electronic/written notification

Technical Denial is issued

No

Provider receives electronic/written notification

Suspend Review *See Note below

Data Entry of Determination.

Denied

Provider receives outcome notification.

Yes

Technical Denial is issued