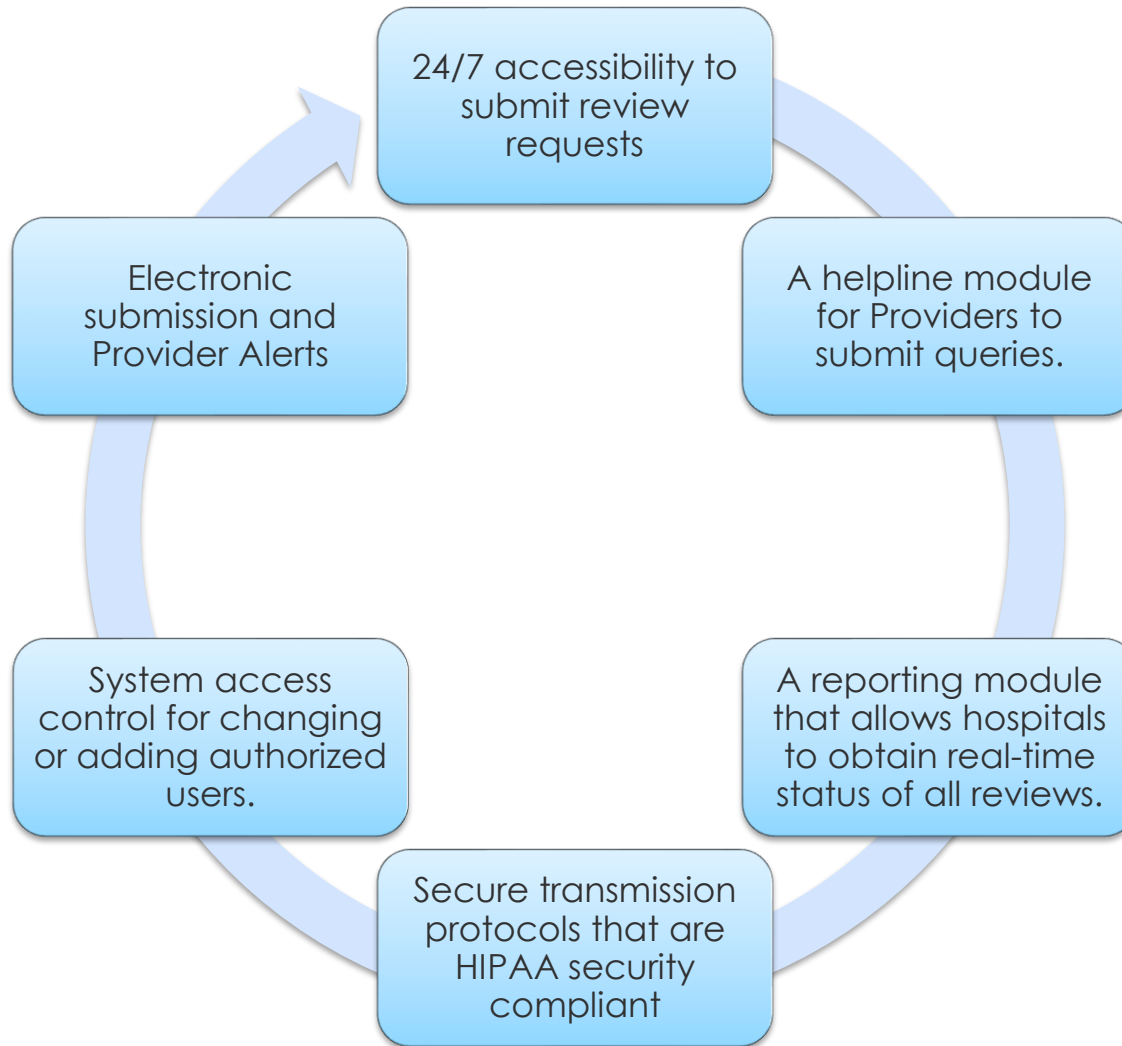


# Advanced Diagnostic Imaging

# Overview of eQsuite®



# How to access eQsuite®



## New Users:

You will need to complete and submit an access form.

*(Once received and entered you will receive an email confirmation with your username and password)*

## System Administrator:

- ✓ The person assigned will be responsible keeping all user accounts updated. *(Email address/phone numbers etc.)*
- ✓ You will have the ability to create additional User Accounts.
- ✓ Keeping all users informed of any updates or notifications sent from eQHealth.

### eQsuite® Access Form

Complete and submit this form to obtain System Administrative Access to eQsuite® for your Group/Practice. Once we create User Access for your provider group the System Administrator will be able to create and manage additional eQsuite® user accounts for your staff.

Please Type in the Fillable Fields and email this form to

PR@Acentra.com Fax: 855-440-3747

*Handwritten Forms Cannot be Accepted*

Providers Information	
<b>System Administrator</b> First/Last Name	
<b>Group/Practice Name</b>	
<b>Mailing Address</b>	
<b>NPI #</b>	
<b>Billing Medicaid ID#</b>	
<b>Phone #</b>	
<b>Email Address</b>	
<b>Service (Provider Type)</b>	Select Service

**IMPORTANT INFORMATION**  
(Please read before signing)

**UNAUTHORIZED ACCESS TO eQsuite® IS PROHIBITED BY LAW**

By signing this form, you are attesting that you understand that accessing eQsuite® is for the sole purpose of conducting Utilization Review and that each logon will be used only by the individual to whom it assigned. Unauthorized or improper use of the eQsuite® product may result in disciplinary action, as well as civil and criminal penalties.

**SAFEGUARDING AND LIMITING ACCESS TO EXCHANGED DATA**

I agree to establish and implement proper safeguards against unauthorized use of eQsuite®. Proper safeguards shall include the adoption of policies and procedures to ensure that the data obtained shall be used solely in accordance with HIPAA.

<b>Signature</b>	
<b>Date</b>	

# Recipient Requirements

## Recipients must be:

- Enrolled in a Medicaid benefit program that covers the services:
  - Fee-for-Service
  - Dually eligible recipients
    - *Medicare/Medicaid*
    - *Commercial/Medicaid*
- Eligible at the time services are rendered\*

### **Note:**

Medically Needy recipients must have active eligibility on the date of service. The date of service and the dates on the PA must be included in the eligibility span.

# Diagnostic Imaging

- **Provider ID:** Enter the rendering facilities Medicaid ID#
- **Choose Service:** Outpatient Diagnostic Imaging
- **Review Type:**
  - Admission (Prior authorization Requests)
  - Retrospective (The imaging test has already been rendered)

Start

**Review Type and Settings**

Provider ID:  Provider Name:

Choose Service:  Physician Procedures  Vision  Audiology  Med/Surg  Outpt Diagnostic Imaging

Review Type:

# Supporting Documentation & Pended Reviews

## Required Documentation

- ✓ Include patient History (*Signs & Symptoms*)
- ✓ Provide previous Imaging testing that has been done
- ✓ Send the physical exam leading up to the need for the request
- ✓ If the test has been done please send a copy of the results

## Pended Reviews

Failure to provide the required supporting documentation may result in the review getting pended for additional information.

- Please make sure to review the pend completely. There may be more than one item that is being requested from the reviewer, failure to respond to the entire request will result in additional pend. This delays the review and delays the recipient getting service.
- Once a review is pended for additional information, upon the receipt of the requested documents the review completion timeframe starts over.

# Review Completion & eQSuite® Status

Prior Authorization	Review Completion Timeframes	Referred to Physician Reviewer (2 <sup>nd</sup> Level)
Initial Admission (Prior Authorization)	Within 1 Business Day Timeframe begins upon the receipt of all required documents	Within 3 Business Days
Retrospective (Applies to retroactive Medicaid Eligibility)	Within 20 Business Days Submit Within 1 year of the retroactive eligibility	Within 20 Business Days

## Review Status Determinations

- PEND: Additional information is being requested
- 1st Level Review: The review is currently being reviewed
- 2nd Level Review: If medical necessity cannot be made at 1st level review gets referred to a physician reviewer
- Cancel: Duplicative Service or line items not entered correctly, No Medicaid eligibility, Untimely Submission

## Reconsideration and Fair Hearing Rights

- Partial and full denials have reconsideration and Fair Hearing Rights. Recipients or their parent/legal guardian need to be made aware of this process. There are time limitations for the requests outlined in the denial letter.

# Modifications to an approved review

Type	Method
Extension of an authorization	<ul style="list-style-type: none"><li>• Contact Customer Service or</li><li>• Enter an Online Helpline Ticket</li></ul>
Change Provider ID	<ul style="list-style-type: none"><li>• Contact Customer Service or</li><li>• Enter an Online Helpline Ticket</li></ul>
Upcode/Downcode (With or W/O Contrast)	<ul style="list-style-type: none"><li>• Contact Customer Service or</li><li>• Enter an Online Helpline Ticket</li></ul>

- We cannot add additional CPT codes to an already entered request.
- If you need to add a CPT code to a review you will either need to cancel the original request and re enter or you can enter a brand new request for the additional codes.

**Note:** If you enter a new request for the additional codes you will need to enter a different start date or you will get a duplicate error.



# Reminders

## Rendering Facility vs Physician

- If the physician is submitting a request for prior auth a second request does not need to be entered by the hospital or facility

## When Authorization is NOT required

- ADI services do not require auth if provided during Hospital Inpatient stays, 23-hour observation, and in the emergency department.  
[Outpatient Hospital Service Coverage Policy Bullet 7.2](#)

## Prior Authorization Number

- The PA number will be available 24-48hrs after the approval has been given

## Pended Reviews

- If a review gets pended, you should **NOT** be entering a new request with the corrections.

## Clinical Questions

- It is important to answer the clinical questions, these drive the review and can reduce the amount of “pends” you receive

## Denials

- If a review gets denied, you have reconsideration and Fair Hearing rights. You should not be entering the request again

# LIVE DEMONSTRATION

# eQHealth Resources

**Phone:** 855-444-3747  
**Fax:** 855-440-3747  
*(General inquiries/questions)*

**Provider Website:**  
FL.Acentra.com  
*(Provider Forms/Education and Training Material)*

**Provider Outreach Email:**  
PR@Acentra.com  
*(Provider Education/Training Assistance)*