eQSuite™ Web User Guide
for
Electronic Review Request
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OVERVIEW OF SYSTEM FEATURES

What Is It?

➢ A Web-based electronic review request submission system allows hospitals to submit admission and concurrent reviews, input discharge dates, and send additional information for previously submitted reviews.
➢ A reporting module allows hospitals to obtain the real time status of all reviews.
➢ An online helpline function.

What Are the Key Features of the System?

<table>
<thead>
<tr>
<th>Features</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ One System</td>
<td>Everything in one, convenient location. Log on to create review requests, run reports, update users, access online helpline, etc.</td>
</tr>
<tr>
<td>✓ New Web Portal</td>
<td>No application to install. Log in to portal through link on our Website at <a href="http://il.eqhs.org">http://il.eqhs.org</a>.</td>
</tr>
<tr>
<td>✓ Easy Accessibility</td>
<td>Same 24/7 access from Website home page. No changes to existing eQHealth user names and passwords.</td>
</tr>
<tr>
<td>✓ Intuitive Review</td>
<td>It’s smart! The Web review is guided by the admitting diagnosis and category of service.</td>
</tr>
<tr>
<td>✓ Added Features</td>
<td>• Field added for updating physician contact information. • Copies medication table from the previous review request.</td>
</tr>
</tbody>
</table>

What Do Hospitals Need To Use the System?
Our Web system is a secure, HIPAA compliant, browser-based Microsoft ASP.NET application which can be accessed over the Internet. The following is a checklist of minimum hardware and software requirements to use the system:

- Computer with Intel Pentium 4 or higher CPU with 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 / Safari 4 or higher
- Broadband internet connection
ACCESSING THE SYSTEM

➤ For New Users Without a Web Account
   - You need to register with us if you do not already have a free Web Account. Fill out a Hospital Contact Form (available on our Website homepage) and assign a Web Administrator for your facility. Your hospital’s eQHealth (Medicaid) Liaison must sign off on this assignment.

➤ For Facilities With a Web Account
   - If you’ve not already received a user ID and password to log on, your hospital-assigned eQHealth Web administrator will provide this log on information, unique to your provider Medicaid ID number. Each hospital-assigned eQHealth Web Administrator has privileges to grant access and create/maintain user IDs and passwords for each user at your facility.

IMPORTANT: Each user is responsible for maintaining the confidentiality of their individual logon. If you believe the security of your logon has been compromised, notify your facility’s eQHealth Web administrator and they can immediately change your password.

Your User ID and password are linked with your hospital’s Provider ID #. If you perform reviews for more than one hospital (i.e. children and general hospital), you need a separate log in ID for each facility. You are required to use the correct log in for the hospitalization.
USER LOG IN - GETTING STARTED

The user will access the eQSuite Web system through our Web site homepage at il.eqhs.org. Users will enter via the eQSuite link located on right side of the homepage.

At User Login, enter your assigned eQHealth User Name and password and click Login. Each user is responsible for the security of their user name and password. The hospital-assigned eQHealth Web Administrator, will create the log in ID and grant access for their hospital users. IMPORTANT: If you feel your log in information has been compromised, immediately ask your eQHealth Web Administrator to change this information.

Each individual log in ID is directly linked with a Provider ID. If you conduct reviews for different facilities, you must use the correct log in for that facility.

Forgot your password?
Click on the link and you will be directed to enter your user name to receive a temporary password. Copy and paste the temporary password and follow directions to reset your password.

Once the system has been accessed, the Provider Reports menu will appear first on your screen, as shown below. All other applications will be displayed as a menu across the top of the page and on the menu tab on the left of the screen.

This Web User Guide will give you instructions to use each of these applications.

SUBMITTING REVIEW REQUESTS ONLINE

To create a new review request (both admission and concurrent review) select “Create New Review” from either the Menu button on left side of screen or at the top of screen.
SUBMITTING REVIEW REQUESTS ONLINE

Start Tab

Each time you click “Create New Review”, the Start tab will appear first. All pertinent information to start review is entered on this tab. This includes patient information, service type, physician information, service dates, days requested, TPL and quality screening questions.

The user must select either Med/Surge or Psych setting and the review type as Admission or Continued Stay. DRG-reimbursed hospitals will use “continued stay” for discharge review.

- **Click Retrieve Data button**
- **Next, you will enter the patient’s Bene ID (RIN) and hit TAB. Verify the name, DOB and sex is correct. If discrepancy, cancel Web review and contact pt accounts or Medicaid eligibility**
- **Enter an Account # (not required) This is offered for your convenience. You may enter your unique Hospital Pt Acct # for reference.**
- **Enter Admit DX (numbers only, no decimal point). eQHealth is contracted by HFS to review only a subset of HFS eligibility admissions. Although the patient may be otherwise diagnosed after admission, you must use the diagnoses given on the physician order for inpatient admission. Codes are ICD9-CM diagnosis codes.**

**NOTE:** It is important to have a clear understanding of the physician’s admitting diagnosis before conducting review. Use the Coding Job Aids available on our Web site home page for a list of all HFS’ admitting diagnoses subject to mandatory concurrent review. Visit [il.eqhs.org](http://il.eqhs.org)
SUBMITTING REVIEW REQUESTS ONLINE

Start Tab

**Physician Medicaid #:** Click **Edit** next to Attending. The Attending Physician is attached to the review and the appropriate review notifications will be sent to this physician.

1. Enter the Physician’s Medicaid # in the white field and hit TAB to auto-populate name and phone# (field only takes numbers). OR you may SEARCH by physician name. Click **Search** to search by name of physician. Verify physician name, address and specialty and click **Select** at the left of the name. This physician’s name and phone# fields will auto-populate into the physician grid. *If the physician is not listed, you must cancel review and call our certification line to request a temporary physician ID to be created by eQHealth.*

2. Use your mouse to check the **Phone on File correct?** box, OR fill in the **Updated Phone** field with current phone number.

3. Click “update” to proceed with review.

*Is there a treating physician or covering physician different than the attending?*

Add the treating physician information, as well. If the treating/covering physician changes at next review point, you must edit or delete this information.

- IMPORTANT: If there is a treating physician entered, this is the phone number our Physician Reviewer will try to contact if they need a peer-to-peer conversation.
SUBMITTING REVIEW REQUESTS ONLINE

Start Tab

Enter the **Inpatient Admit Date** *(xx/xx/xxxx)* or use the calendar function to auto-populate the field. **NOTE:** Please submit reviews within 24 hours of admission, or shortly thereafter while patient is hospitalized. The admit date cannot be a future date.

- **Skip Proposed Discharge Date**
- **Enter Actual Discharge Date (only when applicable)**
  - On admission review for 3 days or less, post-discharge.
  - On a continued stay review (i.e. d/c review) for DRG hospitalizations.

- **Enter the # of Days Requested (for this request).** This is for the patient’s estimated length of stay. **NOTE:** For DRG reimbursed hospital admissions and discharge reviews, always enter in “1”.

- **Select your Category of Service** - 20 is for Medical/Surgical and 21 is for Psych

  If applicable, answer the question for three-day emergency psychiatric admission (for Provider Type 30 – General Hospital). Leave blank if it does not apply.

- **If there are any other outpatient service dates** or pass days outside of hospital, include these dates. Leave fields blank if they do not apply.

- **TPL (Yes or No is required)** – HFS requires this information to be entered if the patient has any other known medical coverage.
  - If you **check yes**, use the pull-down menu to choose the TPL type. Fill in as much information as available in medical record.
SUBMITTING REVIEW REQUESTS ONLINE

Start Tab

- **On the left side of screen, answer all required questions** for quality screening.

  - Are home medications documented?  
    - Yes
    - No
  - Are allergies documented?  
    - Yes
    - No
  - Prior to admission, this patient required all
    - (None)
  - Did the patient require a higher level of care within 24 hours of admission?  
    - Yes
    - No
  - Did patient receive outpatient or ER services prior to Admission?  
    - Yes
    - No

- **Click Check Key button** on bottom left side of screen. The check key performs an eligibility check, searches for duplicate entries and confirms the admitting diagnosis is subject to review. If no review is needed, a message box will be displayed and the user must cancel the review (hit Cancel button at bottom of screen), or a message will appear to check errors (see page 17).

  **NOTE:** If the hospital verifies that participant has/will exhaust Medicare or does not have Medicare Part A for this period, a request must still be submitted. Click the appropriate response and hit OK to continue with Web review.

If there are no issues, the system will display the participant’s contact information. Please verify or add any current contact information from the medical record. **Check the box** that address/phone is verified and hit OK.

When the Start tab is completed, **all other review tabs will appear** next to the Start Tab at the top of the page. Continue with the review request.
EXAMPLE: MEDICAL/SURGICAL REVIEW REQUEST

DX/PROCS Tab

The admitting diagnosis entered on the start tab will appear on this screen and cannot be changed.

For DRG hospitalizations, this tab may be skipped

For per-diem hospitalizations only, include any additional diagnoses:

- For admission requests, click Add at top of the Dx Code to submit any secondary established diagnosis that are known upon admission or determined following admission.
- For continued stay requests, only enter diagnoses that have been assigned since last review. If there are no additional diagnoses, skip this tab.

For Per-Diem and Detox hospitalizations add any procedures and include actual or proposed date of the procedure.

- For continued stay requests, only enter procedures that have been done since the last review. If there are no procedures, skip this section.

If this is a psych review, see instructions on psychiatric reviews (see page 14)

Click Continue button on bottom of screen
**EXAMPLE: MEDICAL/SURGICAL REVIEW REQUEST**

**Vitals/Labs Tab**

- **Enter vital signs and include only abnormal and positive labs or labs pertinent to this patient’s current hospitalization.** The vital signs are required for admission and med/surg reviews.

<table>
<thead>
<tr>
<th>Start</th>
<th>DX/PROC</th>
<th>VITALS/LABS</th>
<th>FINDINGS</th>
<th>DC PLAN</th>
<th>MEDS</th>
<th>SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VITAL SIGNS</strong></td>
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<tr>
<td>Temperature:</td>
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<td>Method: (None)</td>
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<td>Pulse:</td>
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<td>Respiration:</td>
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<td>Blood Pressure:</td>
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<td><strong>LAB RESULTS</strong></td>
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<td>Blood Work:</td>
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<tr>
<td>WBC:</td>
<td>$10^9$/mm$^3$</td>
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<td>HCT:</td>
<td>%</td>
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<td>Hgb:</td>
<td>g/dl</td>
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<td>Hct:</td>
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<td>MCHC:</td>
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<td>Platelets:</td>
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<td>WBC:</td>
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<td>Ph:</td>
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<tr>
<td>pCO$_2$:</td>
<td>mmHg</td>
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<td>pO$_2$:</td>
<td>mmHg</td>
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<td>SaO$_2$:</td>
<td>%</td>
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<td><strong>Chemistries</strong></td>
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<tr>
<td>Blood Ketones:</td>
<td>(None)</td>
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<tr>
<td>Creatinine:</td>
<td>mg/dl</td>
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<td>LDH:</td>
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<tr>
<td>ACL:</td>
<td>unit/L</td>
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<tr>
<td>ACP:</td>
<td>unit/L</td>
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<tr>
<td>Urea:</td>
<td>mg/dl</td>
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<td>BUN:</td>
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<td>Creatinine:</td>
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<tr>
<td>Chloride (Cl$^-$):</td>
<td>mEq/l</td>
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<td>Magnesium (Mg$^2+$):</td>
<td>mEq/l</td>
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<td><strong>Electrolytes</strong></td>
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<tr>
<td>Potassium (K$^+$):</td>
<td>mEq/l</td>
<td></td>
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<tr>
<td>Sodium (Na$^+$):</td>
<td>mEq/l</td>
<td></td>
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<tr>
<td>Calcium (Ca$^{2+}$):</td>
<td>mg/dl</td>
<td></td>
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<tr>
<td>CO$_2$:</td>
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<td></td>
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<tr>
<td>Phosphate (PO$_4^{3-}$):</td>
<td>mg/dl</td>
<td></td>
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<tr>
<td><strong>Enzymes</strong></td>
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<tr>
<td>CPK:</td>
<td>unit/L</td>
<td></td>
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<tr>
<td>Troponin:</td>
<td>ug/l</td>
<td></td>
<td></td>
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<tr>
<td>Lipase:</td>
<td>unit/L</td>
<td></td>
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<tr>
<td>Amylase:</td>
<td>unit/L</td>
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<tr>
<td><strong>Physiological</strong></td>
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<tr>
<td>Height:</td>
<td>inches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight:</td>
<td>lbs</td>
<td></td>
<td></td>
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</tbody>
</table>

**IMPORTANT:** The SAVE/CONTINUE button is used to save your work and to continue with the Web review, click the SAVE/CONTINUE BUTTON ON THE BOTTOM OF EACH SCREEN. If you want to partial save, use the SAVE/CLOSE button to close the review and store it in your partial saved records. Your review will be stored under the Search button on the menu bar until you retrieve it and submit it.
EXAMPLE: MEDICAL/SURGICAL REVIEW REQUEST

Findings Tab
Under the finding tab, the clinical indications, treatments, tests and imaging studies will vary depending on the admitting diagnosis and any additional diagnoses from the DX/PROCS tab.

- If the patient is in Special Unit, select which the patient is receiving care at time of review.
- Skip Special Care unless they are a vent patient

<table>
<thead>
<tr>
<th>SPECIAL UNITS:</th>
<th>SPECIAL CARE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient requires/is receiving care in the (Select only one)</td>
<td>Patient requires/is receiving the following type(s) or special care (Select all that apply)</td>
</tr>
<tr>
<td>ICU - Medical</td>
<td>□ Endotrach w/vent-Acute Illness</td>
</tr>
</tbody>
</table>

Clinical Indications/Treatments/Diagnostics/Imaging

<table>
<thead>
<tr>
<th>CLINICAL INDICATIONS:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Findings</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>Altered Mental Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting (persistent &gt; 24 hrs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inability to tolerate oral meds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure</td>
<td>new onset, x1 at home witnessed, generalized tonic-clonic x1 in ed, confused and lethargic</td>
<td></td>
</tr>
<tr>
<td>Hemodynamic compromise and Dyspnea</td>
<td></td>
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</tr>
</tbody>
</table>

Check and enter only what applies to this specific hospitalization. These fields are common findings related to the admitting diagnosis. Providing this information will give a good clinical picture for eQHealth to help certify the admission or length of stay. **NOTE:** If you check a box, please write a short comment. See example above for Seizure.

- Click **Save/Continue** button on bottom of screen after all findings are selected.
EXAMPLE: MEDICAL/SURGICAL REVIEW REQUEST

DC Plan Tab

Select from drop down anticipated discharge to or discharge reason

Type in current DC Plan. Click Save/Continue

MEDS Tab

For Admission Reviews add Medications (inpatient)

Click Add in the Medication Table. This will open a Code Add/Edit page. Enter the Med name, route, frequency, dosage, start date and “new” med for admissions.

Helpful Tips:
Include all IV, SubQ and IM medications. Include PO medications is being titrated. For PRN medications, include only the dosages the patient actually received. Choose route, frequency, dosage and start date.

Click Add. This will cause the medication to drop in the table. If you need to make corrections to a medication, use the edit or delete function for each medication listed in the Meds grid.
**EXAMPLE: MEDICAL/SURGICAL REVIEW REQUEST**

- **For Continued Stay Requests.** Click Copy Meds from previous review, this will populate the medications table with all medications from your last review point (either admission or last continued stay review).

  Click **Edit** to update any of the current Meds. On the Add/ Edit page:
  
  a. If the meds have *not* changed at all in dosage, frequency or route select “Same”. Click Save Changes.
  
  b. If the meds changed: Click **Edit** and put in STOP DATE. Click Save Changes.
  
  c. At Medications Table, click **Add**. Add medication with new dosage, frequency or route, include start date and click “changed”. Click Save Changes.
  
  d. If the meds have stopped, put in STOP DATE, and click Save Changes.

- Check all medications in the medications table and **click Continue**

**Summary Tab**

- Enter a *clinical summary of where pt came from, medical history/comorbidities, (for detox include substance abuse hx), progression of care, or anything that was NOT addressed in the other tabs.*

Please enter any additional information you feel is needed to complete utilization review here. Note: It is NOT necessary to repeat any information that was already indicated on previous tabs.

**NOTICE:** Include only short clinical summary/progress/history pertinent to this review point (200 word limit)

- **Cancel**
- **Save/Close**
- **Submit for Review**

- **After you fill in Clinical Summary, click Submit for Review.**

Once the case has been submitted, a message will appear that it has been successfully submitted to eQHealth for review and will give a Review ID #, this is the same as the tracking number. Record this number for tracking purposes.
EXAMPLE 2: PSYCHIATRIC REVIEW REQUEST

For a psychiatric review request, complete the Start tab selecting the appropriate fields for psychiatric care. Once the Start tab is completed, all review screens will appear as shown below:

The admitting diagnosis entered on the start tab will appear on this screen.

For per-diem hospitalizations, include any additional diagnoses:
- For admission requests, click Add atop the Dx Code box to submit any secondary established diagnosis that are known upon admission or determined following admission.
- For continued stay requests, only enter additional diagnosis that were not recorded previously. If there are no additional diagnoses, skip this section.

You may edit or delete any of the procedures you added to grid.

Procedures – Click Add atop the Proc Code. Include actual or proposed date.
- For continued stay requests, only enter procedures that have been done since the last review. If there are no additional procedures, skip this section.

You may edit or delete any of the procedures you added to grid.

Enter Baseline GAF and Current GAF Fill in Baseline and Current Global Assessment of Functioning scores if available.

Hit Save/Continue
**EXAMPLE 2: PSYCHIATRIC REVIEW REQUEST**

**Vitals/Labs Tab**

- Temperature: 96.7°F
- Method: (Name)
- Rate: BB
- Respiration: 18
- Blood Pressure: 150/82

**Laboratory Results**

**Blood Work:**
- WBC: 3370/mm³
- RBC: 4.89/mm³
- HCT: %
- Hgb: g/dl
- Platelets: x10³
- PT: 
- PTT: 

**Blood Gas Tests:**
- Source: C (Not selected), A (Arterial), V (Venous)
- O2 Saturation: %
- pH: 
- pCO₂: mmHg
- pO₂: mmHg
- SaO₂: %
- HCO₃: mEq/l

**Chemistries:**
- Blood Glucose: mg/dl
- Blood Ketones: (Name)
- Creatinine: mg/dl
- BUN: mg/dl
- AST (SGOT): units/l
- ALK PHOS: units/l
- Albumin: g/dl
- Calcium (Ca²⁺): mg/dl
- Chloride (Cl⁻): mEq/l
- Magnesium (Mg²⁺): mEq/l

**Urine Cheqs:**
- Protein
- Ketones
- C/OW
- Blood
- Specific Gravity
- Proteinuria
- Glucose
- Ketones
- Blood
- pH
- C/OW
- Protein
- Ketones
- Blood

**Enzymes**
- CK: units/l
- krea: units/l
- AST: units/l
- ALT: units/l
- ALP: units/l

**Physical Exam:**
- Height: 
- Weight: lb
- BMI: 

**For female admissions:**
- Gravidity: 
- Parity: 
- Last Menstrual Period: 
- Post Menopause: 
- Sterilization: 

**COMMON LABS for Psychiatric review:**
- BAC/BAL, CIWA, UDS and HCG/UCG etc for female admissions.
- Height and weight important for eating disorders.
EXAMPLE 2: PSYCHIATRIC REVIEW REQUEST

Symptoms Tab – captures the patient’s thoughts and behavior regarding danger to self and others, level of psychosis, mood, anxiety level, and behavior. **TIP: Use the scroll wheel on your mouse to scroll to view more symptoms.** Click Save/Continue

Functioning Tab – information related to stressors and events and current functioning of the beneficiary and current drug use/abuse. Click Save/Continue

<table>
<thead>
<tr>
<th>Psychological Stressors/Events (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Recent Death</td>
</tr>
<tr>
<td>□ Legal Issues</td>
</tr>
<tr>
<td>□ Work/School Problems</td>
</tr>
<tr>
<td>□ Change in Living Situation</td>
</tr>
<tr>
<td>□ Other (Describe)</td>
</tr>
</tbody>
</table>

Current Functioning

<table>
<thead>
<tr>
<th>Physical/Cognitive</th>
<th>Unable to Assess</th>
<th>None</th>
<th>History (Now Stable)</th>
<th>Mild/Infrequent</th>
<th>Moderate/Frequent</th>
<th>Severe/Acute Crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Appetite</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decreased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor Self-Esteem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Disturbance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Verbal Interaction

| Argumentative      |                  |      |                      |                 |                   |                     |

Treatment Tab – enter the psychiatric treatment history within the last year and current precautions. The treatment history is only needed on admission reviews.

<table>
<thead>
<tr>
<th>Treatment History (Check all that apply within last year)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Type/Frequency of Precautions

<table>
<thead>
<tr>
<th>Suicide</th>
<th>Injury</th>
<th>Elopement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**EXAMPLE 2: PSYCHIATRIC REVIEW REQUEST**

**MEDS Tab**

- **For Admission Reviews add Medications (inpatient)**

![Medication Table Image]

- **Click Add in the Medication Table**  This will open a Code Add/Edit page. Enter the Med name, route, frequency, dosage, start date and “new” med for admissions. OR

- **Pending Medications?**  If medications are not ordered, indicate date and reason

**Helpful Tips:**

For PRN medications, include only the dosages the patient actually received. Choose route, frequency, dosage and start date.

Click **Add**. This will cause the medication to drop in the table on the MEDS tab.

**For Continued Stay Requests.**  Click Copy Meds from previous review, this will populate the medications table with all medications from your last review point.

Click **Edit** to update any of the current Meds. On the Add/ Edit page:

- a. If the meds have not changed at all in dosage, frequency or route select “Same”. Click Save Changes.
- b. If the meds changed: Click **Edit** and put in STOP DATE. Click Save Changes.
- c. At Medications Table, click **Add**. Add medication with new dosage, frequency or route, include start date and click “changed”. Click Save Changes.
- d. If the meds have stopped, put in STOP DATE, and click Save Changes.

- Check all medications in the medications table and click **Continue**
**EXAMPLE 2: PSYCHIATRIC REVIEW REQUEST**

**Summary Tab**

Provide a clinical summary and include where the patient came from, specifics about the patient’s signs and symptoms (i.e. suicide plan, who patient is homicidal toward, etc), drug use hx (when applicable), DCFS notification re: alleged abuse or lock out, and any drug levels (ie: Lithium, Depakote, Tegretol)

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**ERRORS TAB**

When you are on the Start tab and hit the Check Key button; OR when you are the Summary tab and hit the Save/Submit button, the system may find an error that will not allow you to move forward. The message below will appear. You will click OK and proceed to check your errors.

![Error Message](image)

The Errors tab is located on the left side of your screen (next to Menu). This will bring up a list of errors, as shown below. It will tell you which tab and the specific error to be fixed. The example below shows that on the DC tab, the user did not select the discharge plan type.

1. See where error is. For this example, go to the **DC Plan tab** and fill in the correct information **AND 2.** To complete the review after correcting any errors, go to **Summary tab** and click the Submit for Review button.
RESPOND TO REQUESTS FOR ADDITIONAL INFORMATION

If an eQHealth nurse pends a review request seeking additional information to progress with the review, a notice will be sent to your hospital’s eQHealth liaison.

To answer the question(s) online, go to Respond to Add’l Info Tab on the top menu bar.

A list will appear with all records in process in which eQHealth has requested additional information.

a. Choose the correct record by clicking Open on the left side

b. A tab “Add’l Info” will open and will show the question(s). A white box will appear on bottom with date. Please enter the answers into the bottom box and click Save Add’l info button.

c. That information will be attached to your original review and an eQHealth nurse will continue with the review process.

ENTERING DISCHARGE DATES

Enter discharge dates for Per diem reimbursed hospitalizations. To report discharge date after the patient’s discharge, click on Utilities on your Menu bar.
ENTERING DISCHARGE DATES

- The user searches for open discharge dates by
  - The patient’s Bene ID or TAN #
  - By a date range, last day certified OR admit date range

- A list will appear with all records in process in which eQHealth has not yet received a discharge date.

- Once the appropriate patient is listed,
  1. Click Edit on the far left of that field.
  2. Enter the discharge date in the last field.
  3. You must click Update on the far left to save the information.

  Note: If the discharge date was already recorded, that participant’s record will not show up.

IMPORTANT: Quick Tips for DRG-reimbursed hospitalization discharge reviews:

1. On Start Tab - choose Cont Stay review, put in TAN and hit Retrieve data
   a. Include actual d/c date, days requested “1” and answer H&P question
2. Skip DX/PROCs Tab
3. On Vitals/Labs Tab, include d/c vitals (any abnormal labs if done after admission review), hit Save/Continue
4. Skip Findings Tab
5. On D/C screen, discharged to and short explanation: i.e. home with home health,
6. On MEDS Tab, click “Copy Meds from Previous Review” button, include stop dates if applicable
7. On Summary Tab, include d/c date: short clinical summary, progression of care, resolution of symptoms, disposition of patient, and readiness for discharge. Hit Submit

SEARCH for PARTIALLY SAVED RECORDS or PREVIOUSLY SUBMITTED WEB REVIEWS

Click on Search button from menu. List of partial saved records shows first.

List Partial Records

- The list of partial records of Web reviews appears which have not been submitted to eQHealth for review. (If you need to delete, click delete on the far right side of table)

- Click Open to the left of the review in process to go back into the Web review to complete the review request and Submit for Review.
SEARCH for PARTIALLY SAVED RECORDS or PREVIOUSLY SUBMITTED WEB REVIEWS

Search for Previous Web Reviews

- **Search by TAN, request or admit date range or Bene ID (RIN#)**
- A list will appear with all past Web reviews which have been submitted to eQHealth for review. Looking for the TAN? Search by date or Bene ID.

<table>
<thead>
<tr>
<th>Review ID</th>
<th>TAN</th>
<th>Request Date</th>
<th>Requestor Name</th>
<th>Bene ID</th>
<th>First Name</th>
<th>Last Name</th>
<th>Request Type</th>
<th>Admit Date</th>
<th>Provider ID</th>
<th>Provider Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case</td>
<td>336425500</td>
<td>01/05/2011</td>
<td>TANWEB007</td>
<td>TANWEB007</td>
<td>JULIANA</td>
<td>RUBIO</td>
<td>Admission</td>
<td>01/05/2011</td>
<td>999999999991</td>
<td>TEST ST. ELSEWHERE HOSPITAL</td>
</tr>
</tbody>
</table>

- **Click Open.** You cannot change any fields; however, you will be able to see what information your facility entered and you can also copy and paste from the text boxes.

**PROVIDER WEB REPORTS**

*Finding Status of Web Review Requests*
- Reports 1 or 2 captures requests in process

*Finding Status of all Review Requests – Web and Phone*
- Report 1 – shows all review data for a participant (put in RIN# only to get all data)
- Report 3 – shows list of admissions by date range
- Report 4 – shows all completed -certified reviews (no denials)
- Reports 7 and 8 – lists cases with medical necessity denials
- Report 8 – provides full details of completed reviews by eQHealth completed date range
  - If reconsideration was submitted, run this report from the denial date, plus 90 days.