1) Admitting Diagnosis and Orders

1a) If a patient has two diagnoses on admission, do both get certified or does the hospital wait until one is ruled out?
Certification must be obtained when the *admitting* diagnosis, as defined in the UB-92/UB-04 Billing Manual documented by the physician and is listed on HFS' Attachment A, B, or C. (All admitting diagnoses are subject to review for long term acute care hospitalizations). The admitting diagnosis code determines whether admission/concurrent review needs to be performed (this does not apply to Prior Authorization – see section 15 for these requirements). If you are uncertain of the admitting diagnosis code, seek further clarification from the attending physician and/or your hospital's coder. The hospital must provide the admitting diagnosis when requesting certification.

1b) If the hospital reviewer doesn't know the diagnosis code, can eQHealth's nurse provide it?
eQHealth Solutions' utilization review coordinators do not have access to the physician's documented admitting diagnosis. They are not permitted to interpret information provided by the hospital or provide the code without implicit direction from the hospital reviewer. Ultimately, it is the hospitals' responsibility as the treating entity, to provide the admitting diagnosis or the ICD code when they request review.

1**c) What information is needed when the hospital is being asked to provide the admitting diagnosis code and additional diagnosis codes at the time of admission?**
Since it is the admitting diagnosis code that determines whether admission/concurrent review needs to be performed, it is very important that the admitting diagnosis be precise and that it is confirmed that the ICD-9-CM diagnosis code is listed on HFS' Attachment A, B, or C for short term acute care hospitals. These attachments can be downloaded

from HFS' Web site at http://www.hfs.illinois.gov/proqio. All admitting diagnoses for long term acute care hospitalizations are subject to review.
If there are additional diagnoses, it is important to provide these codes for per-diem reimbursed hospitalizations, as well. Because the presence of other conditions may complicate the course of admission or influence the patient's clinical status or treatment plan, eQHealth considers all of this information when assessing the medical necessity of admission or continued stay, the number of days that may be certified and the next review point. The complete clinical picture is necessary to ensure that complications and comorbid conditions are considered prior to rendering a review determination. Providing additional ICD-9 codes for per-diem reimbursed hospitalizations will assist in ensuring that all relevant clinical information is considered.

1d) If a patient is admitted with a diagnosis on Attachment C, but the final diagnosis is NOT on the list, is a concurrent/continued stay review still required?
Yes. Since it is the admitting diagnosis code that determines whether admission/concurrent review needs to be performed, it is very important that the admitting diagnosis be precise and that it is confirmed that the ICD-9-CM diagnosis code is listed on HFS' Attachment A, B, or C. Although a different primary or principal diagnosis may be established or confirmed during the course of the hospitalization, the original admitting diagnosis does not change. The admitting diagnosis for review must match the admitting diagnosis reported on the hospital claim to HFS.

1e) Does a review request still need to be submitted if the patient's admitting diagnosis is not reviewable, but a secondary or principle diagnosis is?
No, it is only the *admitting* diagnosis that determines if the hospitalization is subject to review. The admitting diagnosis is defined in the UB-92/UB-04 Billing Manual and is provided by the physician as the chief reason the patient was admitted into inpatient care. It is recommended that the hospital submit its review request to eQHealth Solutions within 24 hours of the patient's admission, or soon thereafter, if the admitting diagnosis is subject to review. **Detoxification admissions must be requested within 24 hours or the next business day.**

1f) What if the patient's admitting diagnosis changes while in house?
The admitting diagnosis does not change, even though a different principal diagnosis may be established after study. The admitting diagnosis code that is reported for utilization review must match the admitting diagnosis code that is sent to HFS on the hospital's claim.

1g) Can an inpatient admitting order be changed to an order for observation prior to billing?
No, the HFS OIG does not permit retroactive orders or the inference of orders. Instances where an inpatient admission is ordered, and the physician chooses to change the patient status to outpatient observation should be addressed on the claim level using the appropriate condition code.

1h) Can a physician retroactively change or clarify admission orders prior to submitting the initial claim to HFS?
No, the HFS OIG does not permit retroactive orders or the inference of orders.

1i) During medical record review, if eQHealth finds the inpatient order is present but not signed/dated by physician or the order is ambiguous, can the hospital have the physician write a clarification order and resubmit the claim to HFS?
No, the hospital cannot have the physician write a clarification order or resubmit the claim. The OIG Notice of May 24, 2013 sets forth specific requirements for the authentication of orders. The OIG Notice further states that unsigned medical records and inpatient admission orders **are unauthenticated records** and the provider will not be given the opportunity to submit supplemental information.

1j) Do all physician orders need to be written, signed/dated and status clarified before discharge? Can a clarification order be written post-discharge to explain the physician's intent?
The OIG does not permit retroactive orders or the inference of orders. However, the OIG Notice does not state that orders have to be "complete" before the patient is discharged. Please refer to the OIG Notice for requirements for the content and signature of an order.

1k) If a patient is initially in observation, then admitted to inpatient several days later, can the physician order specify to admit to inpatient retroactive to the observation date?
No. The OIG does not permit retroactive orders or the inference of orders.

1l) If we received certification for admission, then the physician changed the patient's status to observation, do we have to perform a second, concurrent review?
No. If the physician chooses to change the patient status to outpatient observation, this should be addressed on the claim level using the appropriate condition code.

CODING

1m) What happens if the admitting diagnosis code at the time of admission certification has a different extension than the code on the claim submitted to HFS?
Any admitting diagnosis code with the same root diagnosis codes on Attachments A and B that requires a 4th or 5th digit extension are subject to review. Therefore, as long as the hospitalization was reviewed, even if the 4th or 5th digit extension reported on the claim differs from the one provided during admission review request, the claim will not be rejected for failure to obtain certification.

Only selected admitting diagnosis codes on Attachment C that require 4th or 5th digit extension are subject to review. The hospital should provide the admitting diagnosis or code at the time of concurrent review request.

1n) When coding guidelines mandate a coding change requiring a 4th or 5th digit code extension and the admitting diagnosis is subject to review will the codes with extension be subject to review?
Yes, when a diagnosis code is subject to review and ICD-9-CM coding guidelines mandate a coding change requiring a 4th or 5th digit, **the 4th or 5th digit code extension will *automatically* be subject to review**. *HFS will not send a notice to providers identifying this type of coding change. Providers were informed of this* requirement on the *HFS Informational Notice* dated 12/01/2004.

1o) Do hospitals have to use coding staff to assign the diagnosis codes for reviews?
It is up to each hospital to make that determination. eQHealth's utilization review coordinators are not coders, do not have the benefit of direct access to the physician's documented admitting diagnosis, and are not permitted to interpret information provided by the hospital. The hospital must provide the ICD-9-CM code when requesting review. eQHealth Solutions encourages the hospital's review staff to consult with their coders or billing staff if assistance is needed.

1p What if an incorrect diagnosis code is recorded for review?
The hospital may contact the eQHealth provider helpline to correct the admitting diagnosis in the review system. The correct admitting diagnosis code will be recorded on the eQHealth Certification of Admission Notice. ***The admitting diagnosis can only be changed under these limited circumstances***:
a) the physician's order shows the correct admitting diagnosis and it is subject to review
b) the admitting diagnosis code is in the same category of service (medical/surgical or psych)
c) the request to eQHealth to change the ADx must be completed prior to billing HFS.

1q) Do the ICD-9-CM diagnostic codes listed on HFS Attachment C apply to all ages/both adult and pediatric?
Yes.

2) Admission/Concurrent Review

2a) Who at the hospital is expected to complete the clinical information for any review request?
The hospital determines the staff to perform this function. The certification process does involve discussion of clinical information. Therefore, careful consideration should be given regarding assignment of this responsibility. The review requires submission of clinical as well as demographic information. eQHealth Solutions will accept the review request and necessary information from any reliable person considered appropriate by the hospital.

2b) What is the process for authorizing inpatient admissions to any level of care?
eQHealth Solutions reviews only acute care medical/surgical and psychiatric inpatient admissions and only for admitting diagnosis codes subject to review by Healthcare and Family Services. eQHealth Solutions does not perform prior-authorization or pre-certification review. The initial (admission) review is conducted after admission. Hospital staff or physicians should submit requests for certification within one business day of admission or shortly thereafter and while the patient is still hospitalized. The admission review request may be submitted to eQHealth via our toll-free certification telephone line or through our Web-based review system - eQSuite™.

2c) Are concurrent review requests mandatory?
Yes. Mandatory concurrent review (certification of admission and continued stay review) was implemented for short term acute care hospitals effective with admissions on and after March 1, 2007 for those admitting diagnoses subject to review. HFS Attachments A, B, and C are downloadable from HFS' Web site at www.hfs.illinois.gov/proqio. Short stays of 3 days or less are also subject to mandatory concurrent review. Effective with

admissions on and after October 1, 2010, all admitting diagnoses are subject to concurrent review for long term acute care hospitalizations.

2d) Is there a penalty for failing to comply with HFS's mandatory concurrent review requirement?
Hospitals that do not follow the mandatory concurrent review process will receive rejections from HFS with the error code A88 – "No Certification on File." Claims that did not receive certification of the admission will not be payable by HFS. If an A88 is received because of an exception to mandatory concurrent review, hospitals must re-bill HFS with a hard copy claim. (see question 2f, below).

2**e) Are there any exceptions to the mandatory concurrent review requirement?**
HFS will allow limited exceptions to mandatory concurrent review in the following circumstances:

- A participant's eligibility was back dated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment at the time of admission.
- The patient remains unresponsive or has a physical or mental impairment during the hospitalization that prevents the hospital from identifying coverage under one of the department's medical programs.
- Other – the hospital must provide narrative description.

2f) If there is an exception to the mandatory concurrent review requirement, how should the hospital proceed?
Claims that relate to an exception must be submitted with a cover memo that identifies the exception and provide supporting documentation as appropriate. The hospital must send this claim to the hospital's assigned HFS Billing Consultant for manual review. Exceptions relating to Medicare Part A exhaust or expiration of MCO eligibility requires verification of these expired benefits. After HFS reviews the exception, if granted, the claim will suspend for retrospective prepayment review.

2g) Are out-of-state hospitals required to do concurrent review?
All Illinois hospitals and out-of-state hospitals in counties contiguous to Illinois must participate in concurrent review for all admitting diagnoses subject to review.

2h) When is an authorization number given for a review request?
Once an approval is made, eQHealth Solutions will issue a Treatment Authorization Number (TAN) specific to the admission or continued stay for tracking purposes only. **The TAN is not recorded on the claim submitted to HFS.** eQHealth Solutions will transmit the admission and number of days certified to HFS. For a timeline of eQHealth determinations, see question 2r) below.

2i) Will I always be dealing with the same Utilization Review Coordinator (URC) for my review requests?
No. Different URCs may be involved in when there are multiple reviews for a single hospitalization. The reviewer who receives the call will have immediate access to the information previously entered into the system. The hospital will not have to repeat the information previously provided.

2j) Is an admission review necessary when a participant has Medicare Part A or other primary payer?
Reviews are performed on all secondary claims except when Medicare Part A is primary (and days are NOT exhausted) and the hospital is billing for the Medicare deductible/co-insurance. If Medicare days are exhausted, or exhaust during the hospital stay, contact eQHealth to request an admission review while the patient is hospitalized.

2k) What if there is not sufficient or incomplete clinical information at the time of admission to complete certification?
If information provided by the hospital is insufficient, eQHealth will pend the review. If the review was initiated by phone, during the call the hospital representative will be advised of the specific information required. Whether conducted by phone or Web, a written notice is sent to the hospital's eQHealth liaison specifying the information needed to complete the review. The hospital may respond to the pended case in eQSuite™, under the *Respond to Addt'l Information* tab. If the additional information is not submitted within one business day, the review will be suspended and remain at this status until the additional information is supplied. The review must be completed and services billed to HFS within their 180 day billing cycle.

When a review is pended, it is important to only provide the answer for the specific question(s) and submit this additional information while the patient is hospitalized. Once eQHealth receives the information, the nurse reviewer will continue the review process.

2l) How can hospitals submit information for review of short weekend admissions, post-discharge?
For admissions involving short stays (three days or less), hospitals may submit review requests within seven calendar days of discharge. These short stays are subject to mandatory concurrent review. **ATTN: The short stay rule does NOT apply to Detoxification admissions. Detoxification admissions must be requested within 24 hours or the next business day.** Requests may be submitted online 24 hours a day, 365 days a year, or by calling the toll-free certification line at (800) 418-4033, 8:00 a.m. to 5:00 p.m., Monday - Friday, except for designated Federal and State holidays. These holidays can be found on the eQHealth Web site under the About Us tab. Requests received outside of regular business hours will be processed the following business day.

2m) How does eQHealth Solutions deal with patients whose admissions are court ordered, especially when eQHealth assigns a specific length of stay?
eQHealth Solutions certifies admissions and continued stays when medical necessity of the inpatient setting is established, including those that are court ordered.

2n) When are hospitals supposed to submit clinical information for continued stay reviews?
A request for a continued length of stay review for all per-diem reimbursed hospitalizations should be submitted to eQHealth the day prior to the last day certified,, or shortly thereafter, when needed. For continued stay review, the hospital provides clinical information starting after the last day certified (for the past 24 hours of care).

The last day certified is noted in the eQHealth certification approval notification and is provided during telephonic review. We also fax a daily list to hospital eQHealth liaisons listing all in-process reviews as a reminder of cases due for continued stay review. This list will specify “P” for a per-diem hospitalization or “D” for a DRG hospitalization.

2o) If an admission review was approved but the hospital did not request a continued stay review, can they still request this review from eQHealth Solutions?
Yes. As long as the hospital has received admission certification from eQHealth and has not sent in the claim to HFS, the hospital may complete a continued stay review and submit the claim for payment within HFS' 180-day claim submission timeframe.

2p) How does eQHealth's utilization review coordinator determine the number of days that are certified for a length of stay requested by the hospital?
eQHealth Solutions' utilization review coordinators reference Truven Health (formerly Thomson Healthcare, Inc.'s) Length of Stay Norms to determine appropriate lengths of stay as a guide. These normative data include adjustments for age, sex, and comorbidity. For requests referred to physician peer reviewers, the physician determines the number of days certified based on the patient's clinical condition, the treatment plan, and the estimated length of stay supplied at the time of the request for review.

2q) How do utilization review requirements affect critical access hospitals?
Critical access hospitals are subject to review requirements and are included under the category of "all hospitals."

2r) What are the turn-around times for admission/concurrent review determinations?
The results of initial admission and continued stay review requests are completed by midnight of the first business day following the day the request was received. The status of the review is given at the time of the phone review and updated in the eQHealth reports available on eQSuite™. Hospitals may view review status and all notifications online 24/7.

2s) Does eQHealth perform utilization reviews of patients from rehabilitation centers (provider type 32) or general acute care hospital rehabilitation units (provider type 30) billing with COS 22?
No, eQHealth only performs reviews for acute inpatient hospitalizations for category of service (COS) 20 and 21.

2t) Does the hospital reviewer have to request an admission/concurrent review from eQHealth Solutions if a patient is admitted with the status of "spend down unmet"?
Yes, a review is necessary when a recipient is in unmet spend down status and if the admitting diagnosis is reviewable on HFS attachments' A-C.

2u) What is the procedure for an admission review if the patient has a temporary recipient identification number?
If a patient is issued a temporary recipient identification number and their admitting diagnosis is subject to review, then an admission review is required. It is important to contact eQHealth Solutions when the patient has been issued their permanent recipient identification number to update the review before sending the claim to HFS.

3) Billing and Reimbursement

3a) Who can hospitals contact to discuss pending claims or questions regarding billing or payment?
Claims are processed by HFS. Hospitals may contact their HFS Billing Consultant at (877) 782-5565.

3b) How are pass days handled with the concurrent review requirement?
Since the patient is not receiving in-patient acute care during pass days, they should be recorded as non-covered days. Only days that are medically necessary will be certified. The non-covered days need to be reflected on the UB-92/UB-04 or 837I (electronic transaction). The covered days on the claim must be equal to or less than the length of stay certified or the claim will be rejected.

3c) If review was completed and certified and we still receive an A88 claim rejection – No Certification on File, what should we do?
The hospital should determine why the claim was rejected. Many times the inpatient admit date or admitting diagnosis on the claim does not match what was given to eQHealth for the certification process. This information must match. The hospital may correct their billing error and resubmit the claim electronically, or for exceptions to mandatory concurrent review, the hospital must bill manually and provide supporting documentation to HFS. All questions regarding claims should be directed to the hospital's assigned HFS billing consultant in Springfield, IL at 877-782-5565.

3d) If an exception to mandatory concurrent review is billed properly with a memo and supporting documentation, why is our hospital receiving a claim rejection?
Exceptions to mandatory concurrent review are reviewed manually. If the exception does not meet the criteria set by HFS, they can deny the claim. These exceptions were defined by HFS in their Informational Notice from February 27, 2007. Go to www.hfs.illinois.gov/hospitals.

3e) We are a DRG-reimbursed facility. After we received an admission certification from eQHealth, we billed HFS and received an A88 claim rejection – why?
Though the admission was certified, the concurrent review process was not completed. DRG-reimbursed hospitalizations require a discharge review for quality screening with the discharge date recorded. Call eQHealth or use eQSuite™ to submit the information needed to complete the review process and then resubmit your claim to HFS. All continued stay reviews must be completed and billed to HFS within their 180-day claims submittal timeframe.

3f) If a patient age 17 is admitted to acute medical care and the wrong provider number is inadvertently given to eQHealth for review, can this be resolved so that it can be billed correctly?
Yes. Call the eQHealth Provider Helpline and explain the situation. Provide the correct provider number for your Children's facility. An error correction can be submitted for that particular review.

3g) Does a facility bill the inpatient admission date or the observation date on the claim to HFS?
The facility bills for the inpatient admit date (per signed/dated physician order). Illinois Medicaid defines that the inpatient admission begins at the date/time of a physician order for the patient to be placed in inpatient care.

4) Coding Review and DRG Validation

4a) Who performs coding review and DRG validations on retrospective reviews?
Coding review and DRG validation are performed by eQHealth Solutions' utilization review coordinators who are registered nurses. These URCs are trained in the principles of ICD-9-CM coding and DRG validation and achieve a level of reliability. Final coding verification on all DRG referral cases is performed by a Physician Reviewer and confirmed by a Certified Coding Specialist.

4b) Is there a list of particular DRGs that are being reviewed for retrospective prepayment review?
Yes, HFS' Attachment D and E contain the list of DRGs that are subject to retrospective prepayment review. Please visit HFS' Web site at http://www.hfs.illinois.gov/proqio to download Attachment D and E.

5) Confidentiality and Patient Privacy

5a) Is eQHealth Solutions considered a "HIPAA business associate?"
Yes. eQHealth Solutions maintains a Business Associate Agreement with the Illinois Department of Healthcare and Family Services.

5b) Do hospitals need to obtain consent to release information prior to calling in clinical information for concurrent review?
No. Since HFS is reimbursing for the care, HFS, or eQHealth Solutions, as its designated Quality Improvement Organization and business associate, has the authority to perform federally required utilization review.

5c) When submitting a review request via the Web-based review system, is the information secure to protect confidentiality?
Information submitted online through eQHealth's Web system is fully secure. The information you send via eQSuite™ is encrypted to ensure confidentiality.

5d) If a patient refuses to sign consent to release information, is a pre-certification call still required?
A consent for the release of information for utilization review is not required since HFS is reimbursing for the care being provided to HFS participants. HFS or eQHealth Solutions, as its business associate, has the authority to perform federally required utilization review of care.

6) Criteria

6a) What criteria are used to determine the medical necessity of inpatient admission and continued stay?
eQHealth Solutions' review nurses apply the most recent version of McKesson's InterQual® medical/surgical, behavioral health, procedural, and long term acute care criteria.

6b) Can facilities obtain copies of the Medical Necessity criteria used?
InterQual® criteria are copyrighted by McKesson. Hospitals may purchase or lease the criteria by contacting them. Click here to visit the McKesson Web site.

7) Denials (Non-certifications)

7a) Who notifies the participant when a non-certification (denial) is issued or a continued stay is no longer medically necessary?
eQHealth does not provide notification of denial to the HFS health plan participant. The hospital or the physician may notify the patient in accordance with its internal policies and procedures.

7b) What types of cases are likely to be denied for admission or continued stay?
If medical necessity of the admission or continued stay cannot be established with the clinical information provided, the admission or continued stay will be denied by the physician peer reviewer. The hospital or physician may request a reconsideration of an adverse determination.

7c) What happens when days are denied?
Non-certified days are reported to HFS on the UB-92/UB-04 or 837I (electronic transaction) as non-covered days, and analyses may be conducted to identify patterns and trends or for various administrative purposes.

7d) What choices do I have if I don't agree with a medical necessity denial?
If the patient has already been discharged, the hospital or physician may submit a request for standard reconsideration within sixty calendar days from the denial date. If the patient is still hospitalized, the hospital or attending physician may request either an expedited reconsideration while the patient is hospitalized or wait until the patient has been discharged and submit a request for standard reconsideration with further clinical information. Additional clinical information must be provided to substantiate the medical necessity of the denied day(s).

8) Determinations and Reconsiderations/Appeals

8a) When a review request is submitted to eQHealth, what are the possible determinations?
A review performed by a **Utilization Review Coordinator** may result in one of the following outcomes:

- **Certification** - InterQual® medical necessity criteria are applied. If criteria are satisfied, the utilization review coordinator renders a medical necessity certification determination for the admission or continued stay. The certifiable length of stay is determined based on the hospital's or physician's reported estimated length of stay in comparison to Truven Health LOS norms which are referenced as a guideline.
- **Pend for additional information** - Additional clinical information may be needed to complete a review. During this time, the review is pended. When the information is received within one business day, it is removed from pend status and the review is completed.
- **Suspend** - When a review is pended and the requested additional information is not received within one business day, the review is suspended.
- **Physician reviewer referral** - When criteria are not satisfied, or the number of days requested exceeds what the nurse may certify, the utilization review coordinator will send the request to a physician peer reviewer.

A review performed by a **Physician Reviewer** may result in one of the following outcomes:

- **Certification** - The physician uses the available information and clinical judgment to render a certification determination. If further information is needed, peer to peer discussion is initiated between the physician reviewer and the treating physician.

- **Adverse Determination** – This is a general term for an unfavorable utilization or quality finding. Specific types of adverse determination include medically necessity denials, confirmed quality of care issues, and change in the billed DRG.

8b) What is an expedited reconsideration?
An expedited reconsideration is an opportunity for a hospital to appeal any adverse review finding while a patient is still hospitalized. The hospital or physician may send the request for expedited reconsideration with additional, clinical information supporting the medical necessity of denied day(s) via mail or fax to eQHealth Solutions. Reconsideration forms are available for download from the eQHealth Web site under the Provider Resources tab.

8c) What is a standard reconsideration?
A standard reconsideration is an opportunity for a hospital to appeal any adverse review finding that may be requested once the patient is discharged. The request must be submitted in writing with pertinent clinical information supporting the medical necessity of denied date(s) to eQHealth Solutions within 60 calendar days from the date of the *Notice of Denial*.

9) Discharge Planning and Discharge Dates

9a) Is any consideration being offered to assist facilities faced with challenging discharges?
eQHealth only performs utilization review to determine the necessity of admission and continued stay, and only medically necessary days are certified.

9b) Would "no available nursing home bed" that is documented in the discharge planning by social services validate a continued stay, i.e., non-avoidable day?
The continued stay must be medically necessary. Regarding days that the patient needs to remain in the hospital due to nursing home placement, these days may qualify for reimbursement under Skilled Care Hospital Residing (category of service 37) or DD/MI Non-Acute Care Hospital Residing (category of service 39). Refer to the HFS Hospital Handbook, Chapter 200 regarding participation requirement and enrollment procedures.

9c) How do I submit a discharge date to eQHealth Solutions?
Hospitals may submit patients' discharge dates for *per diem reimbursed hospitalizations*, on the faxed daily list and fax them back to eQHealth at (800) 418-4039, or online through the Web-based review system by clicking on "*Utility* menu button. For *DRG reimbursed hospitalizations*, the patient's discharge date is entered as part of the concurrent review (discharge) request.

10) DRG Reimbursed Hospitalizations

10a) Does a concurrent review need to be completed for a DRG reimbursed hospitalization?
Yes. Even though DRG reimbursed hospitalizations are no longer subject to a length of stay review, a concurrent review must be completed at the time of discharge. HFS requires eQHealth to conduct a quality of care screening at the time of the patient's discharge.

10b) Will I still receive a daily list if my cases are DRG reimbursed?
Yes. The daily list will show DRG reimbursed admissions with a "D" marked next to it. The "D" marked admissions need to have a concurrent (discharge) review request submitted at the time of the patient's discharge. An asterisk will appear next to a case with an entered discharge date. This indicates that a concurrent review for quality of care screening is still needed. This will stay on the daily list for 90 calendar days or until the concurrent review is complete.

10c) When can I submit a concurrent review for a DRG reimbursed hospitalization?
The concurrent (discharge) review should be submitted when you can provide information about the last 24-48 hours of inpatient care, including the patient's discharge date, resolution of signs and symptoms and discharge disposition (e.g. home with outpatient follow-up, nursing home, etc.).

10d) What is required for a quality of care screening for a DRG-reimbursed discharge review?
eQSuite™ is set up for DRG-reimbursed reviews so that the second DRG review lists appropriate questions regarding the patient's clinical status and quality of care during the 24 hours prior to discharge (when the patient has been admitted for more than 48 hours). If there were any invasive procedures, please add the procedure code and results of any previously pending labs or tests.

11) Eligibility

11a) If a patient has Medicare Part A as primary coverage, but all Medicare days have been exhausted, and therefore Medicaid becomes primary, is concurrent review required?
Yes, if the admitting diagnosis is subject to review, concurrent review is required. At the time of the review request, the hospital must inform eQHealth Solutions that the patient has exhausted or may exhaust Medicare Part A benefits during the hospitalization, or select the option to continue with review online.

11b) If the patient has Medicare Part B only and the admitting diagnosis is subject to review, is a concurrent review required?
Yes.

11c) Is a concurrent review request required for patients with a pending application under one of HFS' medical assistance programs?
No. If the patient's Medicaid eligibility was determined after discharge, the hospital will bill HFS for the services. If the admitting diagnosis is subject to review, HFS may select it for prepayment review.

11d) If the patient's eligibility is determined after discharge and the admitting diagnosis is subject to review, should hospital staff submit a review request?
No. However, HFS will allow limited exceptions to mandatory concurrent review. If the participant's eligibility was backdated to cover the hospitalization, the hospital may submit a hard copy claim to their assigned HFS Billing Consultant with a cover memo that explains the exception. After HFS reviews and approves the exception request, they will pend the claim for retrospective prepayment review. HFS then sends a list of cases to eQHealth for prepayment review. The hospital's eQHealth liaison will be sent a *Notice of Selection of Medical Records for Offsite Review* (prepayment review) when cases are selected.

11e) How can hospitals obtain information about HFS medical assistance programs eligibility after hours, on weekends, and/or holidays?
HFS has established the Automated Voice Response System (AVRS) for client eligibility inquiries. The toll-free telephone number (800) 842-1461 is available 23 1/2 hours a day to allow providers to access client eligibility information through the use of any telephone. To utilize the AVRS, the provider must have the participant's recipient identification number (RIN). Eligibility information consists of whether the participant is eligible for one of HFS' programs, and in which program the participant is eligible specific to the date of service in question. Public Act 88-554 mandated HFS create a statewide

electronic Recipient Eligibility Verification (REV) system. The REV system is available to enrolled providers throughout the state. The REV system utilizes various clearinghouses, known as REV vendors that have direct telecommunication line access into HFS's databases. Additional information on REV system and vendors is available at http://www.hfs.illinois.gov/rev/

HFS also has another site called Medical Electronic Data Interchange (MEDI) which allows the provider the opportunity to verify a participant's eligibility for medical assistance, submit claims or check claims status directly to HFS through the provider's Internet browser software. No additional hardware or special software is needed. The provider may register to use the MEDI system by accessing http://www.myhfs.illinois.gov/

If additional information is needed regarding MEDI, please contact the Customer Center Service Desk at (800) 366-8768 or (217) 524-4784. For a more comprehensive overview of the MEDI System, review the MEDI help document at http://www.myhfs.illinois.gov/training/guides.html.

11f) If there is a discrepancy in the participant's birth date and what is in the State database, eQHealth cannot take the review. It is difficult to provide mandatory concurrent review before this is corrected in the system. What do we do?
If you have an eligibility issue, call the caseworker to get information changed while the patient is in-house. If it is unresolved at the time of discharge, bill HFS with "other" exception, and attach supporting documentation showing the correct date of birth and the date the change of birth date was requested.

12) Hospital's eQHealth Liaison

12a) Who is my eQHealth liaison?
The hospital's eQHealth liaison is the individual designated by the hospital administrator to receive all review-related correspondence from eQHealth Solutions. This individual should distribute this correspondence to other individuals or departments within the facility as appropriate.

12b) Can the hospital change the designated eQHealth hospital liaison?
Yes. Updates or changes in hospital contact information must be requested in writing and signed by a CEO or CFO and faxed to eQHealth Solutions. A hospital contact form can be found on eQHealth's Web site homepage.

12c) Is it possible to have separate hospital eQHealth liaisons for medical/surgical admissions and psychiatric admissions?
No. Only one eQHealth liaison can be assigned per provider identification number (facility).

13) eQHealth Solutions Resources and General Information

13a) What resources do eQHealth Solutions offer hospitals?
Several resources are offered including the following:

- Provider Updates – these information notices and updates are distributed by fax to the eQHealth liaison and posted to the eQHealth Web site.
- Coding Aids - Lists containing reviewable codes from HFS' Attachment A, B and C are conveniently sorted numerically and alphabetically. These may be downloaded from eQHealth's Web site homepage.
- Provider Specific Reports – With a secure log in ID, hospitals may access these through the "Reports and Communications" link on the eQHealth Web site.
- Provider Helpline - The eQHealth helpline is available Monday – Friday from 8 a.m. to 5 p.m. through a toll-free number (800) 418-4045.
- Provider Education - Web-based review system training and general education sessions are offered on a regular basis. Click the Training and Education tab on the eQHealth Web site.

13b) How can hospitals find out when the next Web training sessions will be offered?
Hospitals may access this information on the eQHealth Solutions Web site under the Training and Education tab.

13c) What are eQHealth Solutions' hours of operation?
Normal business hours are Monday through Friday from 8 a.m. to 5 p.m. eQHealth is closed for designated Federal and State holidays. Holiday schedule is listed on eQHealth's Web site on the About Us tab. Review requests may be submitted online 24 hours a day, 365 days a year. Requests received outside of regular business hours will be processed within one business day of our receipt. If hospitals do not have access to computers they may call our toll-free certification line during normal business hours.

13d) Does eQHealth Solutions accept reviews requests by fax?
No. eQHealth accepts requests online through our Web-based review system 24 hours a day, 365 days a year. Concurrent reviews will also be accepted using the toll-free certification line at (800) 418-4033, Monday through Friday from 8a.m. to 5 p.m., except for designated Federal and State holidays. Requests received outside of regular business hours will be processed the following business day.

14) Physicians and Physician Peer Reviewers

14a) What do hospitals do if the physician does not have a HFS provider number?
If the physician does not have a HFS physician number, they should be made aware that this is required. The hospital must call eQHealth Solutions' toll-free certification line at (800) 418-4033 to receive a temporary ID for the physician. Hospitals may then submit their requests by Web.

14b) How are physician peer reviewers matched to the case they are reviewing?
Physician peer reviewers are matched by specialty and/or service provided.

14c) Are hospital physicians given an opportunity to interact by phone with physician peer reviewers and supply additional information?
Yes. The eQHealth physician reviewer will make one attempt to contact the treating physician to discuss the review before any adverse determination (medical necessity non-certification, confirmed quality of care issue, or DRG change) is made. The hospital or attending physician may request a reconsideration of an adverse determination.

14d) For physician review of child psychiatric cases; will there be a child psychiatrist available to review the cases?
Child psychiatrists are among eQHealth Solutions' physician peer reviewers. Every effort will be made to match the physician peer reviewer's experience with that of the patient's attending physician.

14e) Is there a penalty to physicians for non-medically necessary hospitalizations?
No. The physician's claim and the hospital's claim are not linked. We will notify both the hospital eQHealth Liaison and the attending physician when a review results in an adverse determination such as a medical necessity non-certification (denial).

14f) Does the hospital physician receive reimbursement if the case has non-certified days?
Physicians receive payment for physician services, regardless of non-certified days.

15) Prior Authorization

15a) Who is responsible for submitting a Prior Authorization request?
The hospital is responsible for submitting review requests to eQHealth. To assist hospitals, a template has been created to communicate with the physician office what pertinent clinical information is needed for review. The *Prior Authorization Template - CABG* and the *Prior Authorization Template-Back Surgery* are located under the PriorAuthResources/Provider Forms Tab on our Website.

15b) Why is the hospital responsible for submitting a Prior Authorization review request when they do not have the clinical information needed for the review?
The policy established by Healthcare and Family Services (HFS) requires the hospital to request a prior approval. The SMART Act mandated the use of prior approval process for elective CABG and back surgery procedures.

15c) Will Medicaid Participants be notified of this new service?
No.

15d) Does eQHealth Solutions accept Prior Authorization requests by fax?
No. eQHealth accepts prior authorization requests online through our Web-based review system, eQSuite™. Hospitals can access eQSuite™ 24/7 at their convenience.

15e) Do out of state hospitals in contiguous counties have to request Prior Authorization?
Yes, hospitals in both Illinois and contiguous counties are required to submit a prior authorization request when applicable.

15f) Will Prior Authorization reviews be subject to RAC audits?
Yes.

15g) Since the hospital is the responsible party and this new service requires additional resources and planning, will HFS allow a grace or transitional period?
HFS' Provider Informational Notice was issued on February 5, 2014 effective for elective general inpatient admission beginning April 1, 2014, providing hospitals with a two month transitional period in order to plan accordingly.

15h) Does HFS want Prior Authorizations on back surgeries for all primary, secondary, or third party Medicaid payers?
Yes, it would be good measure to request prior authorization when Medicaid is secondary; if patient accounts/finance believes the primary coverage may exhaust or not cover the procedure.

15i) What if Medicaid eligibility is not established prior to admission for a procedure on HFS Attachment F?
As with other types of utilization review, certain HFS exceptions to this approval process may apply, if:

- A participant's eligibility was backdated to cover the hospitalization.
- Medicare Part A coverage exhausted while the patient was in the hospital, but the hospital was not aware that Part A exhausted.
- Discrepancies associated with the patient's Managed Care Organization (MCO) enrollment occurred at the time of admission.
- Other – the hospital must provide narrative description.

Please contact a UB-04 Billing Consultant at HFS at 1-877-782-5565 if the hospital believes one of the above exceptions applies.

15j) Will concurrent review be performed for Prior Authorization requests?
No, concurrent review will not be performed. See question 15o).

15k) If the patient is in inpatient status at a hospital (i.e. admitted with angina or severe back pain); then condition persists to where CABG or Back Surgery is scheduled a few days later, does this require Prior Authorization?
No, prior authorization is not required in these cases. Prior Authorization is required when the procedure is the reason for inpatient admission (planned/elective admission).

15l) If a patient is admitted with chest pain and discharged, then a CABG is scheduled in two weeks does this require Prior Authorization?
Yes. This is considered a planned/elective procedure.

15m) If a patient comes into the emergency room and suddenly needs one of the elective surgeries, how can it be pre-authorized by a physician if they didn't know the patient needed it?
In this case, the surgery would not be elective (planned). If the patient is already in the hospital (admitted) and needs this type of surgery it is not elective - it may be considered emergent by the physician. HFS does not require Prior Authorization for an emergent procedure. Prior Auth is required when the procedure is planned and the procedure is the reason for being admitted to the hospital.

15n) If the primary dx code submitted for Prior Authorization review changes, do we need to contact eQHealth to change it on the review?
No. The requirement for Prior Authorization is based on the procedure code (HFS Attachment F). The procedure code will be transmitted to HFS when approved. Although diagnoses codes are submitted to eQHealth, Providers do not need to update the diagnosis code with eQHealth if there is a change.

15o) If an admission has an admitting dx code that is on Attachment C (reviewable) and there is a prior authorization on file for an ICD9 procedure on Attachment F, will the case require both prior authorization and concurrent review?
No. HFS provider notice issued February 5, states: Concurrent review will not be performed. The QIO will only approve the procedure, not the length of stay. See question 1l). Hospitals enrolled as Long Term Acute Care (LTAC) hospitals are exempt from these review requirements, as all of their inpatient admissions require certification of admission and concurrent/continued stay review.

15p) Some CABG patients may be admitted a day before surgery for an IV heparin drip. The actual procedure will be performed the following day. There are two date fields for review, the admission date and the procedure date. In the procedure table, do we put the inpatient admission date or the date of the actual procedure?
Per HFS' hospital handbook, hospitals cannot bill days prior to the procedure so the admission date and the procedure date should match on the review.

15q) What criteria are used to determine the medical necessity of the procedure?
eQHealth Solutions' review nurses will apply InterQual® 2013 procedural criteria to screen for medical necessity of the procedure.

Physicians/Surgeons – Prior Authorization

15r) Have all Medicaid physicians been notified of this new service?
Yes. HFS' Provider Informational Notice was issued to all hospitals and Medicaid physicians. In addition, the notice is posted on the HFS Website. Providers wishing to receive e-mail notification, when new provider information is posted by the department, may register at the following: http://hfs.illinois.gov/provrel.

15s) Will the physician/surgeon be penalized if the case gets denied?
Currently, the physician/surgeon will not be penalized if the approval is denied.

15t) If a review is referred to an eQHealth Physician Reviewer, does peer-to-peer contact occur?
Prior to rendering an adverse determination, the eQHealth Physician Reviewer will make one attempt to contact the physician/surgeon. NOTE: If consent has been granted by the surgeon, the surgeon may assign either a registered nurse (RN) or a physician assistant (PA) to be the primary contact when a peer-to-peer interaction occurs. Hospitals must update the physician's contact information in eQSuite™ (on Start tab) if the telephone number differs from that of the physician.

15u) If a review is referred to a 2nd level Physician Reviewer (reconsideration), and a determination is rendered, will the hospital and surgeon be notified?
Yes. eQHealth will auto-fax the eQHealth Liaison and physician/surgeon one of the following notifications based on the outcome:

- Notice of Reconsideration Determination-Reversed
- Notice of Reconsideration Determination-Upheld

Notifications can be viewed and printed by the hospital from eQSuite™.

15v) What do hospitals do if the physician does not have a physician ID number from HFS?
If they do not have a physician ID number, the hospital may call eQHealth Solutions' Provider Helpline (800) 418-4045 to receive a temporary ID for the physician. Once this TP# is assigned, the hospital will submit their review through eQSuite™.

15w) If the Prior Authorization is referred for physician review, can the eQHealth Physician speak with a registered nurse or a physician assistant instead of the surgeon?
Yes. If consent has been granted by the surgeon, the surgeon may assign either a registered nurse (RN) or a physician assistant (PA) to be the primary contact when a peer-to-peer interaction occurs. Hospitals must update the physician's contact information in eQSuite™ (on Start tab) if the telephone number differs from that of the physician.

15x) Why can't the surgeon's office initiate the review request? Can the hospital grant a user name and password to the physician office and have them submit the request?
The policy established by Healthcare and Family Services (HFS) requires a member of hospital personnel to request a prior approval.

Billing and Claims for Prior Authorization

15y) Who can hospitals contact for questions regarding billing or payment?
Each hospital has an assigned HFS Billing Consultant and should direct all billing questions to them at (877) 782-5565. eQHealth is not involved with billing or claims for Medicaid services.

16) Psychiatric Review

16a) Who performs admission certifications for psychiatric admissions to an inpatient unit?
The reviews are performed by eQHealth Solutions' utilization review coordinators who are registered nurses applying InterQual® Behavioral Health Criteria, a nationally-recognized screening criteria. All nurse reviewers are trained to apply behavioral health review criteria, and some have several years of inpatient psychiatric nursing experience. In addition, our physician reviewers, board certified in psychiatry, are available to provide ongoing training and consultation when necessary.

16b) How are pass days handled with the concurrent review requirement?
Since the patient is not receiving in-patient acute care during pass days, they should be recorded as non-covered days. Only days that are medically necessary will be certified. The non-covered days need to be reflected on the UB-92/UB-04 or 837I (electronic transaction). The covered days on the claim must be equal to or less than the length of stay certified or the claim will be rejected.

16c) What is the procedure when a patient is admitted for a medical condition that does not require admission review, but during the stay, the patient's primary diagnosis changes to a psychiatric diagnosis?
The hospital must discharge the patient from the medical service and admit the patient to the psychiatric service, using the appropriate admitting diagnosis. When this occurs, it changes the category of service for the inpatient stay. *The hospital must submit separate claims if there is a change in the category of service.* If the admitting diagnosis is subject to concurrent review for the inpatient stay, a certification of admission must be requested. In this case, the clinical information for the psychiatric condition will need to be provided to eQHealth within one business day of the admission for acute inpatient psychiatric care.

16d) If a patient requiring a psychiatric admission presents to the ER, is the ER staff required to call for pre-certification before transferring the patient to the psychiatric unit?
No. eQHealth Solutions does not perform prior-authorization or pre-certification review. Hospital staff or physicians should submit admission review request within 24 hours of the patient's admission or as soon thereafter as possible.

16e) What is the procedure if a child requires admission for psychiatric services?
Hospitals are reminded that for child and adolescent psychiatric hospitalizations, the hospital must notify the Crisis and Referral Entry Service (CARES) prior to admission. A Screening, Assessment and Support Services (SASS) provider must conduct an assessment and be involved in discharge planning. Unless CARES records their involvement in the admission in eQHealth's computer system, eQHealth is not able to proceed with the review. The hospital may contact CARES at (800) 345-9049. Additional information regarding the Children's Mental Health Program is available on HFS' Web site at www.hfs.illinois.gov/sass.

16f) If a patient is transferred from a general hospital to an inpatient psychiatric facility, which is responsible for obtaining admission certification?
The psychiatric facility should submit the request for review after the patient has been admitted to inpatient status at their facility.

17) Quality Screening/Quality Review

17a) When a hospitalization is reviewed through the admission/concurrent review process, is it reviewed for quality?
Yes. Behavioral health hospitalizations and medical/surgical hospitalizations are subject to a concurrent quality screening process. The concurrent quality screening is performed to identify potential quality of care issues. Should a potential quality of care issue be identified in the concurrent review, it will only be confirmed after a full chart review by a physician peer reviewer.

17b) What is the difference between quality of care screening and quality review?
The quality of care screening is conducted during the admission/concurrent review process. It is based on the information provided by the facility via phone or web submission. A comprehensive quality review is conducted during a retrospective review only. Please see definitions for more complete explanation.

17c) Who determines if a quality issue exists?
Only a physician peer reviewer can determine if a quality of care issue exists and only after review of the entire medical record. Validation of a serious quality of care issue and quality of care pattern are determined only after review by a physician peer review panel. The physician peer review panel consists of at least three physicians of the same specialty of the cited physician/care.

17d) If we receive notification of a potential quality issue, are we required to respond?
When a potential serious quality of care issue is identified, the cited party is offered an opportunity to submit additional information about the concern or discussed with a physician peer reviewer. Though a response is not required, it is in the interest of the cited party to provide any information that might be relevant to the quality concern before a final determination is rendered.

17e) Are quality determinations reported to any outside entity?
The quality of care determinations are reported, in writing, to the Bureau of Medical Integrity (BMI) and to HFS regarding the validated quality issue. The cited party(ies) are notified of the final determination with a request of Quality Improvement Plan (QIP).

17f) What is a QIP and is it requested whenever a quality issue is identified?
A QIP is a Quality Improvement Plan. A QIP is requested when a serious quality issue (s) is validated by a physician peer review panel. A QIP can also be requested if a pattern of quality issues is identified.

17g) If a quality improvement plan (QIP) is requested, how long will QIP monitoring be required?
The length of time required for quality improvement plan (QIP) monitoring is case-specific based on the monitoring results. The monitored results need to support that the QIP is achieving and maintaining the target goals. Four quarters of monitoring is typical for most QIPs. The Quality Improvement Plan may be extended if the anticipated target goals are not being achieved and/or sustained.

18) Reports and Notifications (Review Letters)

18a) What notification will I receive once a determination has been made?
Notifications depend on the review outcome and, for some reviews, the method by which the review was performed.

- Certification (approval) of medical necessity for review requests made by phone: The hospital will receive immediate verbal notification of certification. Also, a written notification will be sent to the hospital's eQHealth liaison. Hospitals set-up with auto fax will receive a fax notification. All others will be

mailed. The hospital may also check the review status and determination online through eQHealth's provider specific Web reports.

- Certification (approval) of medical necessity for reviews requests submitted online: A written notification will be sent to the hospital's eQHealth liaison. Hospitals set-up with auto fax will receive a fax notification. You may also check the review status and determination online.
- Non-certification (denial) of medical necessity: Before rendering a medical necessity non-certification determination, one attempt is made by the physician reviewer to contact the treating physician by phone. During the phone conversation, our physician reviewer informs the treating physician of the determination. eQHealth also provides phone notification to the hospital representative who submitted the review request. If eQHealth calls to advise the hospital representative of the non-certification and is routed to an answering machine or voicemail, a message containing any patient information cannot be left unless the voicemail greeting specifically states that it is a confidential or secured voicemail box or answering machine. Written notifications are mailed to both the hospital's eQHealth liaison and the attending physician and include an explanation of the reconsideration process. Hospitals may also check the review status and determination online through eQSuite™ Web Reports.

18b) Will the hospital be notified if they need to submit a concurrent/continued stay review request?

eQHealth faxes a daily list of all in-process reviews to the hospital's eQHealth liaison. These in-process reviews have had an admission review completed. The daily list will show a "D" marked for DRG reimbursed hospitalizations and a "P" marked for Per diem hospitalizations. Depending on the type of hospitalization, the case will need either a continued stay review or a discharge review submitted. For per diem reviews, the hospital will submit a continued stay review request if additional days need to be certified. For DRG reviews, a concurrent (discharge) review must be submitted by the hospital for a quality of care screening to complete the review process.

18c) What reports are available to a hospital?

A variety of provider specific reports are available online through the eQSuite™ link on the eQHealth Solutions' Web site. To access these reports, the hospital's eQHealth Web administrator must assign a user name and password and give access to "Run Reports" to appropriate personnel.

18d) Will eQHealth Solutions' certification notifications include the date that it was sent?

Yes. The written Notice of Review Approval or Notice of Denial is dated. The date of submission of the hospital's request for certification is also included.

19) Retrospective Review – Medical Record Review

19a) What is the procedure for sending in medical records to be reviewed retrospectively?
The hospital's eQHealth liaison will receive a Notice of Selection of Medical Records for Offsite Review. The hospital copies and mails the chart(s) to eQHealth within 14 calendar days from the date of notice. The hospital will be reimbursed copying charges on a quarterly basis, at the rate of $0.10 for each page or $0.20 for double-sided pages.

19b) What is reviewed during retrospective review?
The medical necessity of the admission, each day of care and the appropriateness of invasive procedures are reviewed. In addition to the medical necessity and appropriateness reviews, HFS requires eQHealth to conduct quality of care review, validate the accuracy of billed ICD-9-CM and DRG codes, and review for critical billing errors. Critical billing errors are not part of the prepayment review for Cesarean Sections.

19c) Will an eQHealth Solutions utilization review nurse be coming to the hospital to perform retrospective reviews?
No. In an *Informational Notice* dated November 28, 2006, HFS notified hospitals that effective March 1, 2007, eQHealth (formerly HSI) will conduct only off-site reviews for all diagnosis codes and DRGs subject to review. Hospitals are required to submit the medical record to eQHealth Solutions. **19d) Once a continued stay review is certified, will the same case ever be selected for retrospective post-payment review?**
Yes, selection for post-payment review is probable. The case may be selected as part of a retrospective post-payment review sample to review for quality of care, to validate the information provided during concurrent review, and/or to review for coding accuracy.

19e) Why is a length of stay review performed and days certified for DRG-reimbursed hospitalizations during retrospective review?
Per HFS, the certified length of stay for a DRG-reimbursed claim may affect the claim payment: a) The certified length of stay and the associated covered charges can affect the determination of a cost/day outlier, b) If the provider is eligible for other add-on payments such as Disproportionate Share, MHVA, or MPA the certified length of stay affects these add-on payments since they are per day add-ons for the approved covered days, or c) The total covered charges for the certified length of stay is also used in determining the base payment for claims that are paid at the lesser of either the Department's calculated payment, or the provider's covered charges.

20) Web Administrators and Web Reviews

20a) When entering a Web review, how can I move to the next field?
After entering in the data field, press the TAB key to advance to the next field. Only use the ENTER key when in a documentation field.

20b) Is there a way to copy and paste information from other electronic files into your Web review system?
Yes, eQHealth's Web-based system is Microsoft® Windows-based so hospitals may use the convenient copy and paste feature. However, it is crucial that the clinical information pasted into the review screens should be pertinent and specific to the review request. Concurrent review is not medical record review, do not paste pages or sections of the electronic chart. Please review the information and delete all extraneous data.

20c) What if there is not enough space when typing in the patient's information in the clinical summary screen?
Our system allows for up to 250 words in the clinical screen. Per the Web User Guide, type across the entire line in the clinical screens and let the automatic word wrap take it the next line. It is important to only include a brief clinical summary that is pertinent and necessary for the concurrent review. DO NOT paste progress notes, lab results, etc. Only paste brief clinical summary. Include why the patient is admitted to inpatient services, the progression/regression of s/s and short medical/psych hx. **20d) What if the admitting diagnosis code (Admit DX) is invalid or not subject to review?**
If an error message pops up that the admitting diagnosis code is an invalid code, double check to make sure there is not a typo or that no periods were used in this field. eQHealth posts Coding Job Aids on our Web site, which are lists of the ICD-9-CM admitting diagnosis codes subject to review. If the code is not valid or not subject to review, cancel out of the review. Call the provider helpline if you need assistance.

20e) What if my User Identification (ID) and Password are invalid?
User IDs and passwords are case sensitive, use lowercase when typing. If this does not work, please contact the hospital's designated eQHealth Web Administrator. The Web administrator has the ability to look up and verify User IDs and passwords, and check user's access for submitting Web review requests. If your Web Administrator is unavailable, call our Provider Helpline for assistance.

20f) Is there a way to print out a Web review request to keep in the patient's medical record?
Yes, after submitting the review request, write down the "Review ID" given when you submitted the Web review. Go to the Reports button on the main menu tab. Use Report #17, *Printout of Web Entered Review Request* (the Review ID is needed to print the Web review.

20g) Is there a field to add in the attending physician's correct phone or pager number? If not, where do I put the physicians contact information in a Web review?
Yes. When you fill in the physician information on eQSuite™, you will verify that the phone number on file is correct, OR you may enter the updated phone number. If you want to include an additional phone or pager number, please enter it on the Summary tab after your clinical summary.

20h) What if our hospital's eQHealth Web Administrator is unavailable or unable to answer questions?
Hospital's should call our toll-free Provider Helpline at (800) 418-4045 and explain the issue. The helpline coordinator will ask for verification of your user name, provider ID number and contact information. The provider helpline is available Monday through Friday from 8:00 a.m. to 5:00 p.m., C.S.T.

20i) What if an error message pops up reading "This is a Children's Mental Health Admission and there is no corresponding entry on file from CARES/SASS"?
The participant/diagnosis combination requires that the individual in question be enrolled in the Screening, Assessment and Support Services (SASS) program. Hospitals are required to contact the Crisis and Referral Entry Services (CARES) prior to admission for individuals requiring SASS involvement. Upon contacting CARES, the hospital should indicate that they need an eQHealth entry number – CARES will create an entry and provide the number for the hospital. Please note that eQHealth cannot proceed with the review process until CARES has made their required entry. The CARES line can be reached at (800) 354-9049.

20j) What type of information is required for certain fields in the Web-based review system?
The eQHealth Solutions Web User Guide is a great reference which can be downloaded from the Web site. There are Web review guides for DRG-reimbursed review and Per-Diem reimbursed Behavioral Health review, as well as Prior Authorization review.

20k) Is the information secure and protects confidentiality when submitting a review request via the Web-based review system?
Yes. Information submitted as part of the online review request process is encrypted to ensure confidentiality.

20l) How can hospitals find out when the next Web training sessions will be offered?
Hospitals may access the Web training updates from the eQHealth Web site homepage, by clicking on the Training and Education tab. They may also contact the Provider Helpline to request individual training classes.

20m) What should a hospital do when entering in a Web review request and an error message pops up stating "covered under Medicare Part A - no review needed" but the hospital knows that Medicare Part A coverage has been exhausted for the patient? Effective June 25, 2008, a new "Medicare Benefits" feature allows hospitals to complete a review request online after verifying the Medicare Part A benefit status. After the "Check Key" is clicked, if the system check finds the participant has Medicare Part A, a message will appear and prompt the requestor to **click OK** .After **Medicare Part A benefits are verified by the hospital**, the requestor will be able to choose the appropriate option regarding the participant's present benefit status and may continue with the review.

20n) I don't have a user name and password for the Web system, how do I obtain one?
To obtain this, please contact your hospital's eQHealth Web Administrator. Your facility may have different eQHealth Web Administrators for Utilization Review and Prior Authorization. If you need further assistance, you may contact our Provider Helpline at (800) 418-4045, Monday through Friday 8:00 am to 5:00 pm.