Mississippi Medicaid:

Telligen Provider Review Training – Hospice

August 2025

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Housekeeping

Questions

- Please enter all questions into the chat
- Any unanswered questions will be answered and posted to the website

Survey

- All registrants will be sent a Survey via email following today's training. Telligen welcomes your feedback and suggestions on future training opportunities.

Feedback

- For specific complaints or to provide feedback on the review process, please send your concerns through our Provider Help Desk via Email: msmedicaidum@telligen.com or Toll-Free Phone: 855-625-7709

Purpose of the Presentation

The purpose of this presentation is to:

- **Troubleshoot** authorization submission issues.
- **Enhance Navigation Skills** in Qualitrac platform effectively.
- **Educate Providers** on processes , required documentation and guidelines for Review Request.

Agenda

- Housekeeping Items
- Contact Information
- Review Timing Overview
- Verifying Eligibility
- Entering Physician Information
- InterQual
- RFI, Change Request and Discharge Task
- Appeals & Denials
- Website Tour
- Questions

Contact Us

Education Manager – Primary Point of Contact

Charity A Jones chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager

Claudia Collins

Assistant Program Manager

Cassandra Bullock

Understanding Key Review Terms & Processes

Review Timings

- **Prospective**—Review submitted before services begin, covering future dates
- **Concurrent**—Initial review for services already in progress, covering a date span under one authorization. Concurrent reviews are ongoing admission.
- **Retrospective:** Retroactive authorizations are applicable when there has been a change in coverage, and the patient is determined to be retroactively eligible. The start and discharge/end dates must occur before the request date.

The timing of a review in Qualitrac is determined by when the services are/were provided

Verifying Eligibility

Verifying Eligibility

Why Eligibility Verification Matters

- Confirms active Medicaid coverage for the date of service
- Avoids denials due to eligibility issues
- Provides details on benefit plans, managed care assignments, and limitations

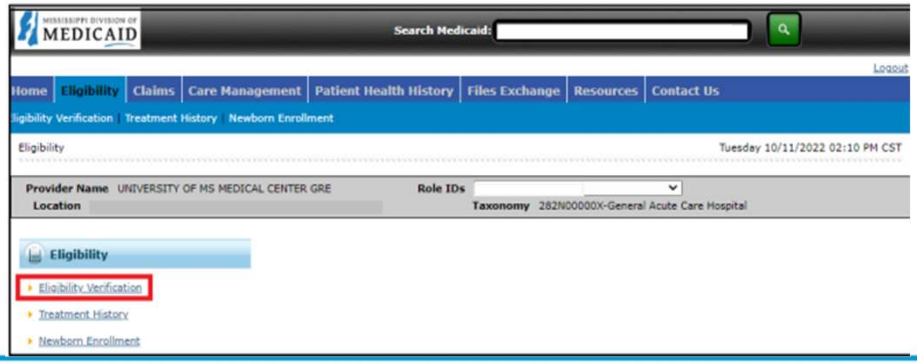
Telligen reviews only beneficiaries enrolled in the TXIX Benefit Plan, except for three specific review types.

- Swingbed services
- ICF-IID
- KBP (formerly DCLH)

Key Takeaways

- Verify eligibility **before** submitting Prior Authorization Request
- Verify eligibility **before** providing services





Verifying Eligibility

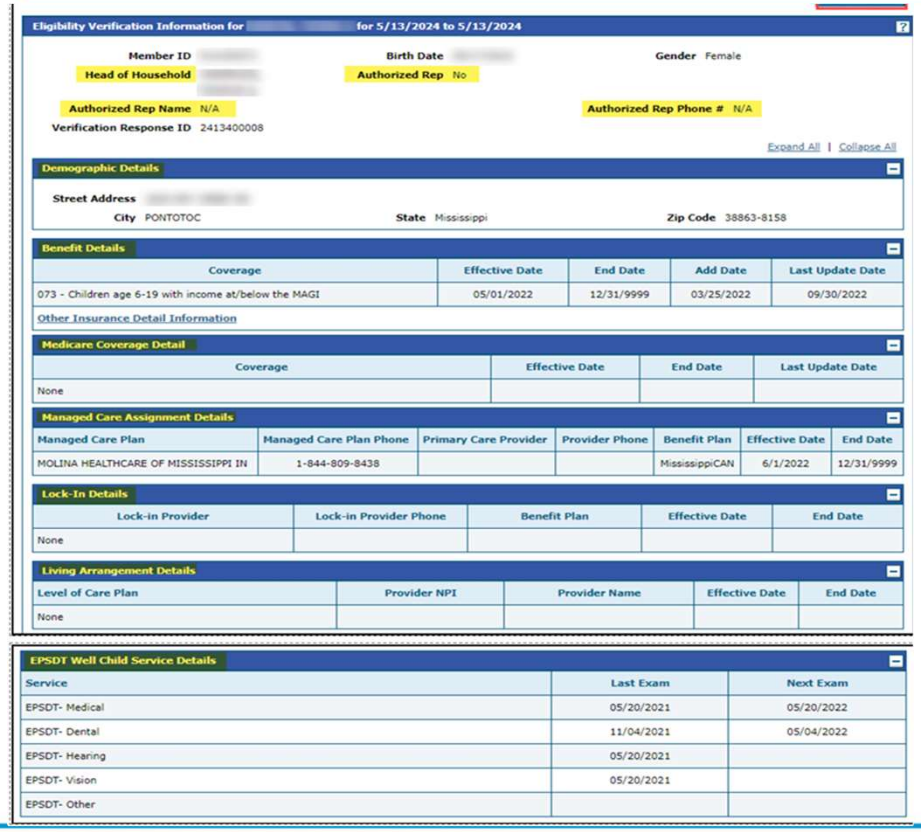
1. Enter the Member ID, or if you don't have it, enter two of the following: SSN• DOB or Member's Full Name
2. Enter the Begin Date and the End Date





Verifying Eligibility

Beneficiary Record Summary



Eligibility Verification Information for [redacted] **for 5/13/2024 to 5/13/2024**

Member ID [redacted] **Birth Date** [redacted] **Gender** Female
Head of Household [redacted] **Authorized Rep** No
Authorized Rep Name N/A **Authorized Rep Phone #** N/A
Verification Response ID 2413400008

Expand All | Collapse All

Demographic Details

Street Address [redacted]
City PONTOTOC **State** Mississippi **Zip Code** 38863-8158

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
073 - Children age 6-19 with income at/below the MAGI	05/01/2022	12/31/9999	03/25/2022	09/30/2022

Other Insurance Detail Information

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	6/1/2022	12/31/9999

Lock-In Details

Lock-in Provider	Lock-in Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

EPSDT Well Child Service Details

Service	Last Exam	Next Exam
EPSDT- Medical	05/20/2021	05/20/2022
EPSDT- Dental	11/04/2021	05/04/2022
EPSDT- Hearing	05/20/2021	
EPSDT- Vision	05/20/2021	
EPSDT- Other		

The system returns the eligibility verification for the member including the following: applicable

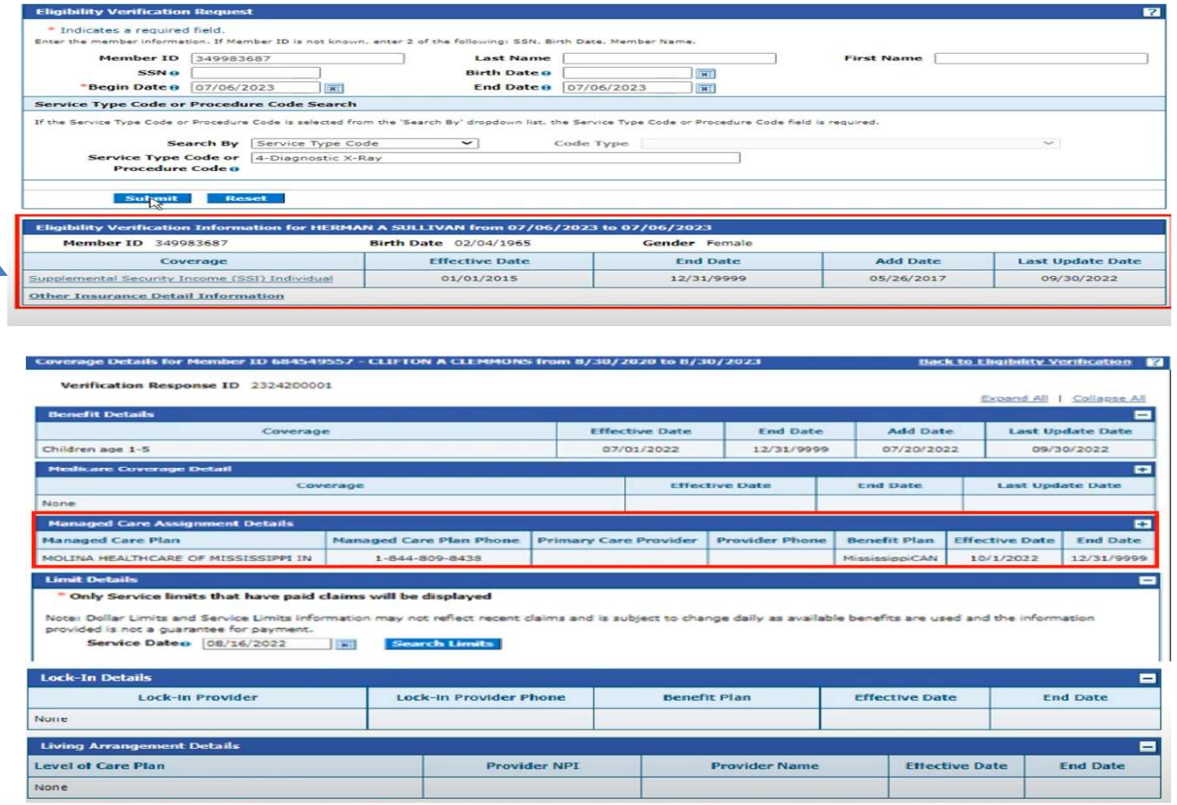
- Head of Household
- Authorized Rep Name
- Authorized Rep Phone #
- Demographic Details,
- Benefit Details
- Managed Care Details
- Lock-In Details
- Living Arrangement Details, and EPSTD details.

Remember, coverage is not a guarantee as a member can lose eligibility for a variety of reasons

Verifying Eligibility

Beneficiary Record Summary

To see more of the benefit plan, click the Medicaid Policy link.



Eligibility Verification Request

* Indicates a required field.

Enter the member information. If Member ID is not known, enter 2 of the following: SSN, Birth Date, Member Name.

Member ID 349983687 | Last Name | First Name

SSN | Birth Date

*Begin Date 07/06/2023 | End Date 07/06/2023

Service Type Code or Procedure Code Search

If the Service Type Code or Procedure Code is selected from the 'Search By' dropdown list, the Service Type Code or Procedure Code field is required.

Search By: Service Type Code | Code Type

Service Type Code or Procedure Code: 4-Diagnostic X-Ray

Submit | Reset

Eligibility Verification Information for HERMAN A SULLIVAN from 07/06/2023 to 07/06/2023

Member ID 349983687 | Birth Date 02/04/1965 | Gender Female

Coverage	Effective Date	End Date	Add Date	Last Update Date
Supplemental Security Income (SSI) Individual	01/01/2015	12/31/9999	05/26/2017	09/30/2022

Other Insurance Detail Information

Coverage Details for Member ID 68454955J - CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 | Search Limits

Lock-In Details

Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

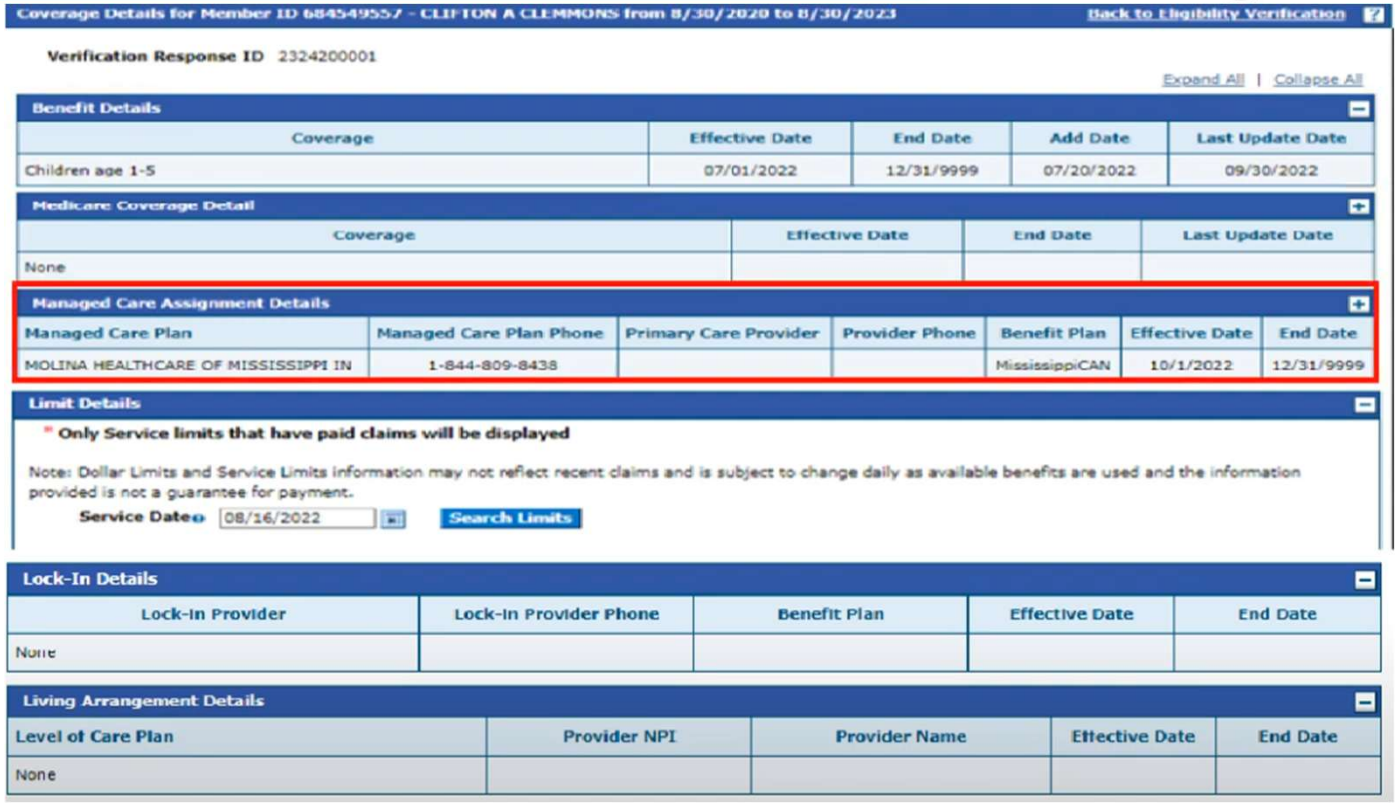
Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Eligibility

Beneficiary Record Summary

The Benefit Screen

- Benefit Plan
- Medicare Coverage Detail
- Manage Care Details
- Lock In Details & more



Coverage Details for Member ID 684549557 – CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 Search Limits

Lock-In Details

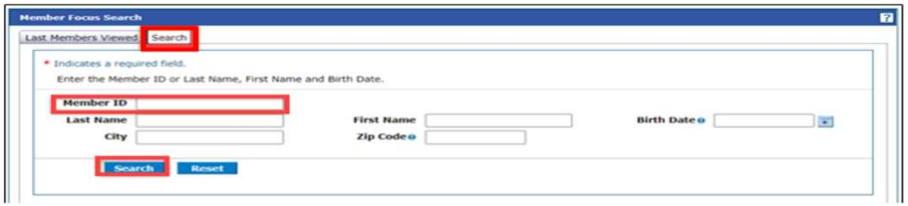
Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

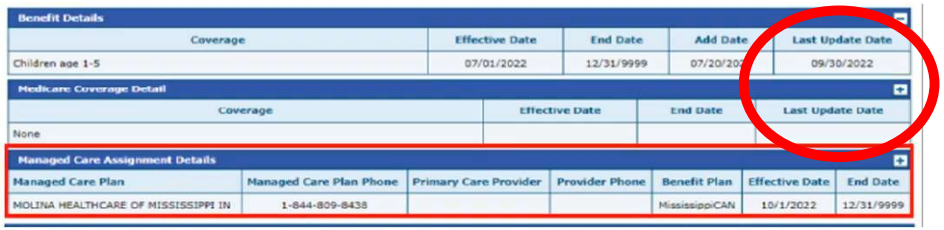
Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Retro Eligibility







1. To view Retro Eligibility, log into the portal, and select the Member Focused Viewing Link found at the bottom, left side of the home page.

2. Select the Search Tab, enter the Member ID, and select Search.

3. This shows you the member demographics, the original effective date, and the end date of coverage.

Per Mississippi Medicaid Admin Code Title 23, Part 200, Rule 1.8, claims denied for untimely filing may only be reviewed if the member has retroactive eligibility and prior authorization (if required) was obtained within 90 days of the eligibility add date.

Timely filing depends on whether the date of service is before or after the add date:

Retro Vs. Not Retro Eligible

Date of Service (DOS): 2/4/2025

Benefit Add Date in MESA: 4/2/2025

📌 **Explanation:**

The Date of Service occurred **before** the add date, the patient is **retro eligible**.

The provider now has **90 calendar days from the Add Date** to submit a prior authorization request.

Date of Service (DOS):

6/2/2025

Benefit Add Date in MESA:

3/25/2024

📌 **Explanation:**

The Date of Service occurred after the add date, the patient is **not retro eligible.**

Verifying Physician / Facility Information

SS1

Providers Panel: Physician and Provider Information

Providers: This section requires information related to who is ordering and providing the care:

- ***Treating Physician*** – The person **providing** the care
- ***Treating Facility*** – The **organization** providing the actual care. (Hospice Provider)
- ***Ordering Provider-*** The person or organization **ordering** the care
- **Medical Director-**The person who **oversee** the care; this can be the treating physician

Providers *

Type	Name	NPI	Address	Phone	Primary Taxonomy	PPO Redirect Reason	Comments	Action
Treating Physician *	The clinician providing the care				Medicaid Provider ID			+ Add
Treating Facility *	This should be the Hospice Provider				Medicaid Provider ID			+ Add
Ordering Provider *	The person or organization ordering the care				Medicaid Provider ID			+ Add
Medical Director *	The Medical Director can also be the treating physician providing the care				Medicaid Provider ID			+ Add

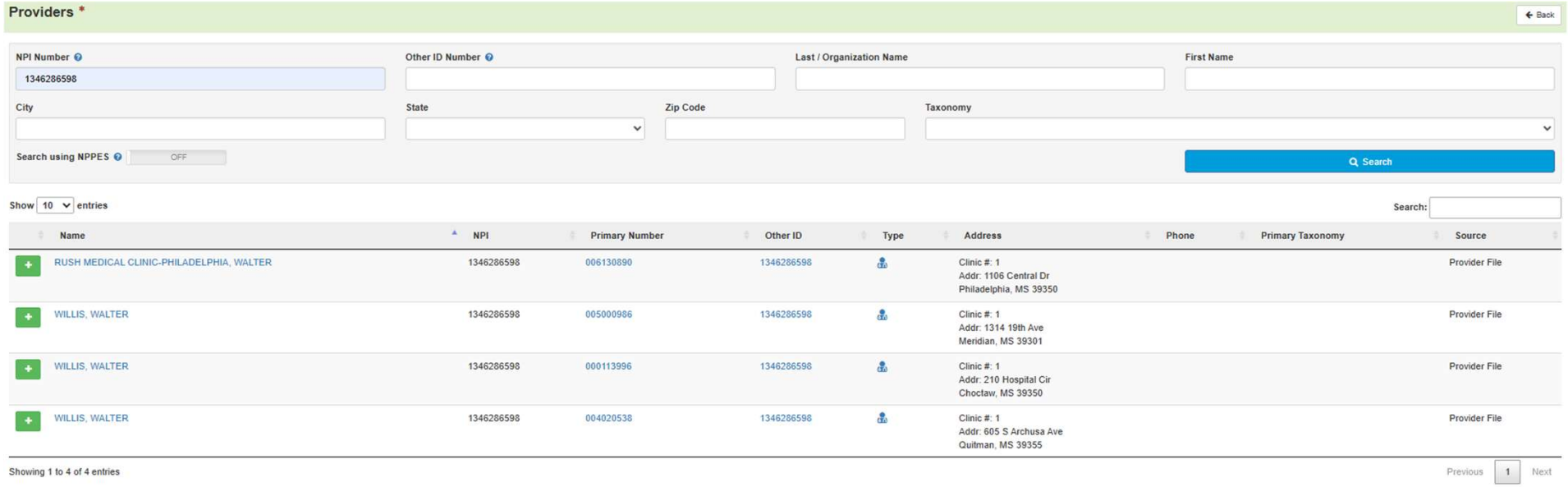
Slide 17

SS1 The information below listed with the blue star is not clear for reading or understanding. Please adjust the location and/or formatting of the information.

Shawana R. Scott, 2024-11-13T20:37:46.089

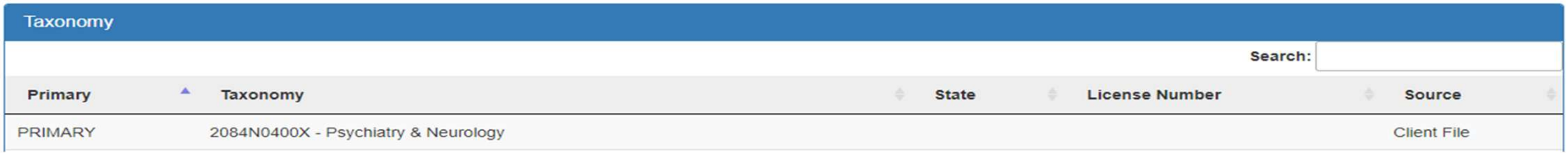
Entering Physician and Facility Information by NPI

- **Clicking** + Add will open a search box. You can search by entering an **NPI number**, Medicaid ID, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.

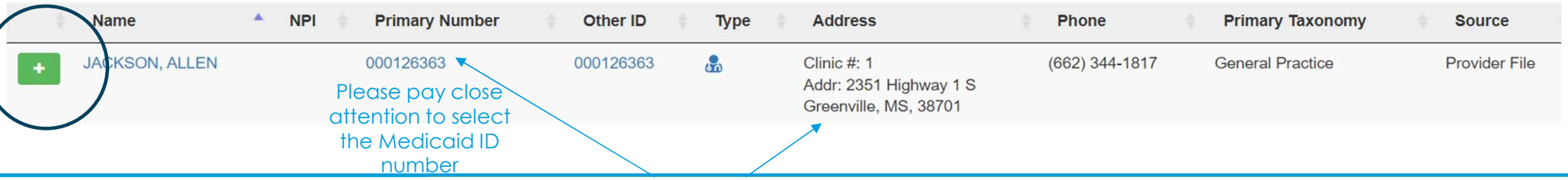


Entering Physician and Facility Information

- Clicking search will return **all** results that meet your entered criteria.
- Click the blue hyperlink in the provider's name to view additional details.
- Check the provider details before selecting, validating the correct provider and the taxonomy ID align to the services being requested



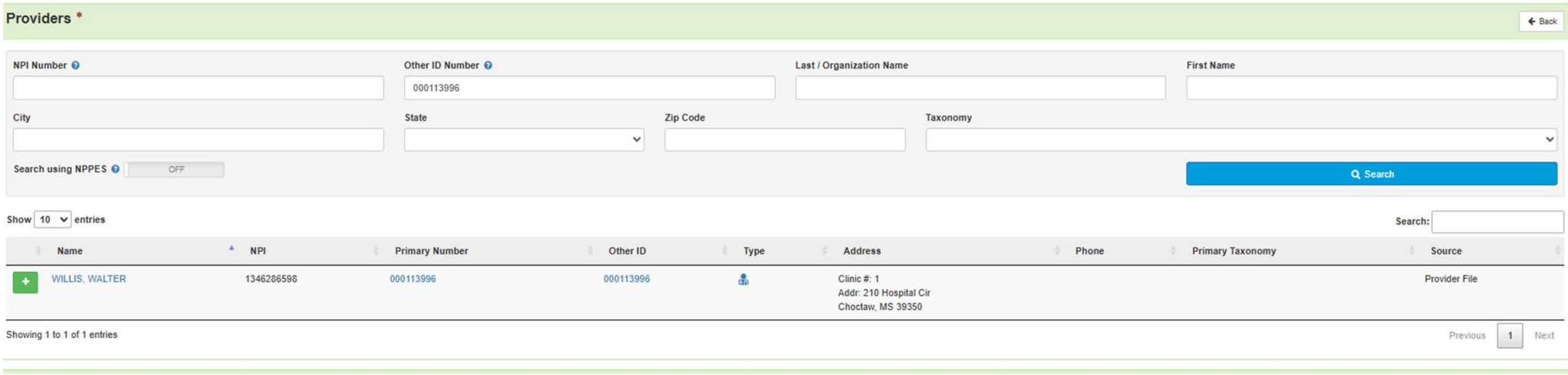
- Use the green plus box next to the name to select the provider/facility that you need for the review.



Please pay close attention to the name and location selected. Example: Hospice Services LLC vs Hospice Services Inc. This is an important point because some providers have multiple locations under the same NPI and possibly similar name.

Entering Physician and Facility Information by Medicaid Provider ID

- **Clicking** + Add will open a search box. You can search by entering an NPI number, **Medicaid ID**, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.



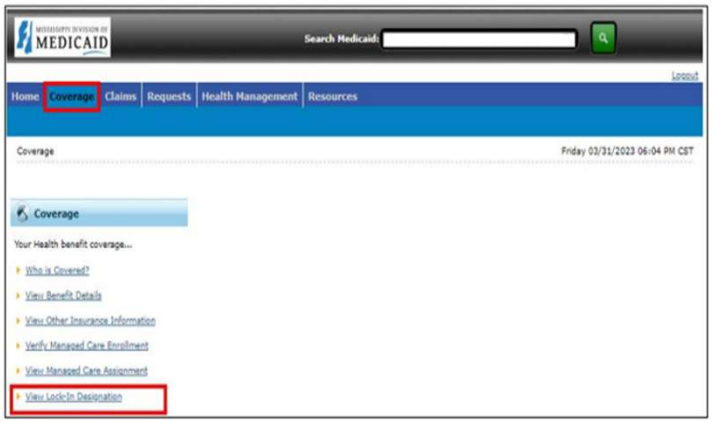
Understanding Provider Lock-In

Lock-in Purpose and Verification

A lock-in date is a restriction set by Medicaid that limits a beneficiary to a specific hospice provider for their healthcare services. The purpose of the lock-in date is to ensure **the beneficiary** receives services exclusively from the designated provider(s) until they are no longer under that provider's care.

The purpose of the lock-in date **for providers** is to ensure they receive payment at their contracted rate. Therefore, it is crucial for providers to use the correct Medicaid Provider Number to align the lock-in date with the appropriate facility and location.

View Lock-In Designation on the MESA Portal, see image



The Lock-In Designation page displays the Lock-In Designation for the selected member.

Within the member's eligibility information, locate the Lock-In Details section.

- Lock-In Provider's Name and Phone Number: The designated provider to whom the member is restricted.
- Lock-In Benefit Plan: The specific plan under which the lock-in applies.
- Effective and End Dates: The start and end dates of the lock-in period.

Verifying Lock In Details

1. Enter the Member ID, or if you don't have it, enter two of the following: SSN• DOB or Member's Full Name
2. Enter the Beain Date and the End Date





Verifying Lock In Details Under the Beneficiary Record Summary

The system returns the eligibility verification for the member including the following: applicable

- Lock-In Details

Remember, coverage is not a guarantee as a member can lose eligibility for a variety of reasons

MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	6/1/2022	12/31/9999

Lock-In Details

Lock-in Provider	Lock-in Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Documentation

Why Documentation Matters in Utilization Review

Accurate, thorough documentation is the foundation of medical necessity. Whether you're submitting an initial request, concurrent review or a continued stay, your documentation tells the patient's story — and justifies the level of care you're requesting.

Top Tips for Strong Documentation

Tell the full story.
Don't assume the reviewer knows the patient — give clinical context from the beginning.

Be timely.
Use **current clinical status** and **up-to-date labs/imaging** — not old notes.

Focus on function and risk.
Explain what the patient **can't do**, why they need **this level of care**, and **what would happen without it**.

Clarify transitions.
If requesting continued stay or extension, include progress and reason for continued need.

Use objective data.
Vitals, lab values, imaging, and measurable outcomes strengthen the case.

Do's & Don'ts of Clinical Documentation

✅ Do	❌ Don't
Document **diagnosis + onset + clinical presentation**	Assume "diagnosis" alone proves necessity
Provide **labs, vitals, imaging, response to treatment**	Use vague statements like "patient doing well"
Show **why current level of care is required**	Leave out why lower level of care isn't appropriate
Update records **daily** for inpatient/concurrent reviews	Submit outdated progress notes
Include **functional limitations or safety risks**	Forget to document why patient still needs care
Match documentation to **review criteria (InterQual)**	Submit generic info without criteria alignment

Do's & Don'ts of Clinical Documentation

Unacceptable alterations:

- White-out or scribbled corrections
- Overwritten/scanned changes without signatures
- Created internal forms used by DME provider to submit request

Acceptable methods:

- Original Clinical Document from the provider
- Line through + initials + date
- New version labeled "Corrected" with signature/date

All documents must include:

- Signature/date
- Two beneficiary identifiers (e.g., Name + Medicaid ID)

Required Documentation-Initial Election & New Admissions

- Hospice Election Notice (Form 1165A): Submit with initial or new election authorization
- Physician Certification of Terminal Illness (Form 1166C or 1166A):
  - **Must be signed within 2 calendar days of the start of the election period**
- Plan of Care (POC): Submit with initial request
- Current Medication List: Submit with every review
- Physician Orders: Include with initial review

All documentation must be dated and signed. All documentation must include 2 beneficiary identifiers For example – beneficiary name and Medicaid ID number or beneficiary name and date of birth (DOB).

Required Documentation-Recertification & Continued Stay Reviews

- Updated Physician Certification (1166C/1166A):
  - **Required for each recertification period**
- Face-to-Face Encounter (Form 1165C):
  - **Required for the 3rd and subsequent 60-day periods; must be completed within 30 days prior to the recertification date**
- Clinical/Medical Documentation:
  - **Submit to support ongoing terminal status**

All documentation must be dated and signed. All documentation must include 2 beneficiary identifiers For example – beneficiary name and Medicaid ID number or beneficiary name and date of birth (DOB).

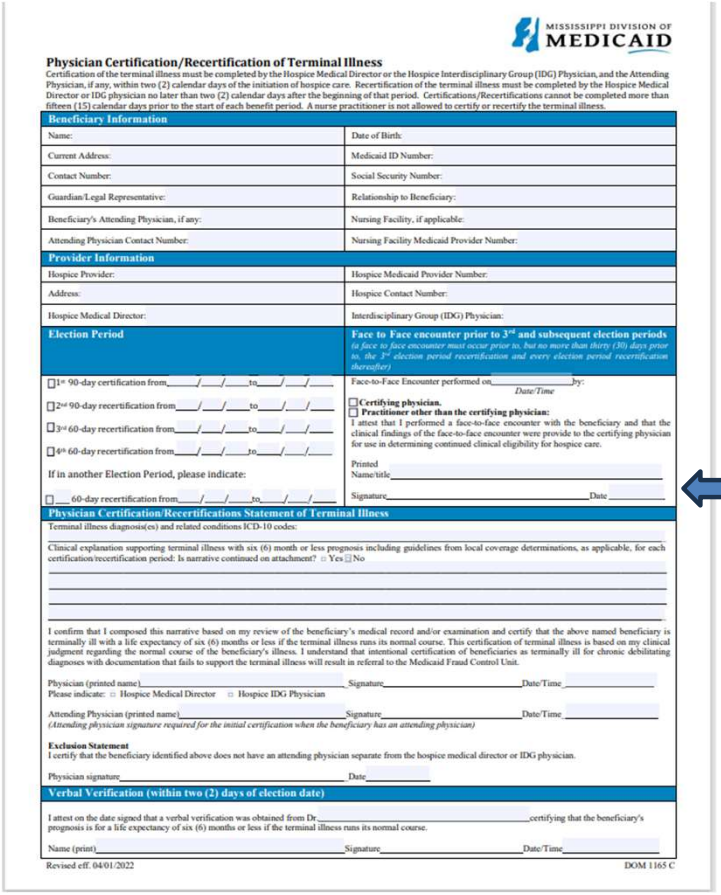
Required Documentation-Discharge & Transfers

- Discharge Summary:
  - **Submit if the member has been discharged prior to the review**
- Revocation/Discharge Form (Form 1166A or 1166C):
  - **Submit within 5 calendar days of the discharge or revocation date**
- Transfer of Hospice Providers (Form 1166B):
  - **Submit when member transfers between providers along with new election documentation**

All documentation must be dated and signed. All documentation must include 2 beneficiary identifiers For example – beneficiary name and Medicaid ID number or beneficiary name and date of birth (DOB).

Required Documentation: Recertification

- Recertification of the terminal illness must be completed by the Hospice Medical Director or Treating physician no later than two (2) calendar days after the beginning of that period.
- The recertification needs to be updated, signed, and narrative included if it is the 3rd benefit or above.
- Face to Face encounter is required for the 60-day recertification period. A face-to-face encounter must occur prior to, but no more than thirty (30) days prior to, the 3rd election period recertification and every election period recertification thereafter.
  - Note: If a nurse practitioner or physician completes the face-to-face recertification, complete and sign DOM Form 1165C.
  - Recertification narrative needs to be included in the review.



MISSISSIPPI DIVISION OF MEDICAID

Physician Certification/Recertification of Terminal Illness

Certification of the terminal illness must be completed by the Hospice Medical Director or the Hospice Interdisciplinary Group (IDG) Physician, and the Attending Physician, if any, within two (2) calendar days of the initiation of hospice care. Recertification of the terminal illness must be completed by the Hospice Medical Director or IDG physician no later than two (2) calendar days after the beginning of that period. Certifications/Recertifications cannot be completed more than fifteen (15) calendar days prior to the start of each benefit period. A nurse practitioner is not allowed to certify or recertify the terminal illness.

Beneficiary Information

Name:	Date of Birth:
Current Address:	Medicaid ID Number:
Contact Number:	Social Security Number:
Guardian/Legal Representative:	Relationship to Beneficiary:
Beneficiary's Attending Physician, if any:	Nursing Facility, if applicable:
Attending Physician Contact Number:	Nursing Facility Medicaid Provider Number:

Provider Information

Hospice Provider:	Hospice Medicaid Provider Number:
Address:	Hospice Contact Number:
Hospice Medical Director:	Interdisciplinary Group (IDG) Physician:

Election Period

☐ 1st 90-day certification from ___/___/___ to ___/___/___

☐ 2nd 90-day recertification from ___/___/___ to ___/___/___

☐ 3rd 60-day recertification from ___/___/___ to ___/___/___

☐ 4th 60-day recertification from ___/___/___ to ___/___/___

If in another Election Period, please indicate:

☐ ___ 60-day recertification from ___/___/___ to ___/___/___

Face to Face encounter prior to 3rd and subsequent election periods

(a face to face encounter must occur prior to, but no more than thirty (30) days prior to, the 3rd election period recertification and every election period recertification thereafter)

Face-to-Face Encounter performed on _____ (Date/Time) by:

☐ **Certifying physician.**
☐ **Practitioner other than the certifying physician:**

I attest that I performed a face-to-face encounter with the beneficiary and that the clinical findings of the face-to-face encounter were provide to the certifying physician for use in determining continued clinical eligibility for hospice care.

Printed Name/title _____

Signature _____ Date _____

Physician Certification/Recertifications Statement of Terminal Illness

Terminal illness diagnosis(es) and related conditions ICD-10 codes:

Clinical explanation supporting terminal illness with six (6) month or less prognosis including guidelines from local coverage determinations, as applicable, for each certification/recertification period: Is narrative continued on attachment? ☐ Yes ☐ No

I confirm that I composed this narrative based on my review of the beneficiary's medical record and/or examination and certify that the above named beneficiary is terminally ill with a life expectancy of six (6) months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the beneficiary's illness. I understand that intentional certification of beneficiaries as terminally ill for chronic debilitating diagnoses with documentation that fails to support the terminal illness will result in referral to the Medicaid Fraud Control Unit.

Physician (printed name) _____ Signature _____ Date/Time _____
Please indicate: ☐ Hospice Medical Director ☐ Hospice IDG Physician

Attending Physician (printed name) _____ Signature _____ Date/Time _____
(Attending physician signature required for the initial certification when the beneficiary has an attending physician)

Exclusion Statement
I certify that the beneficiary identified above does not have an attending physician separate from the hospice medical director or IDG physician.

Physician signature _____ Date _____

Verbal Verification (within two (2) days of election date)

I attest on the date signed that a verbal verification was obtained from Dr. _____ certifying that the beneficiary's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course.

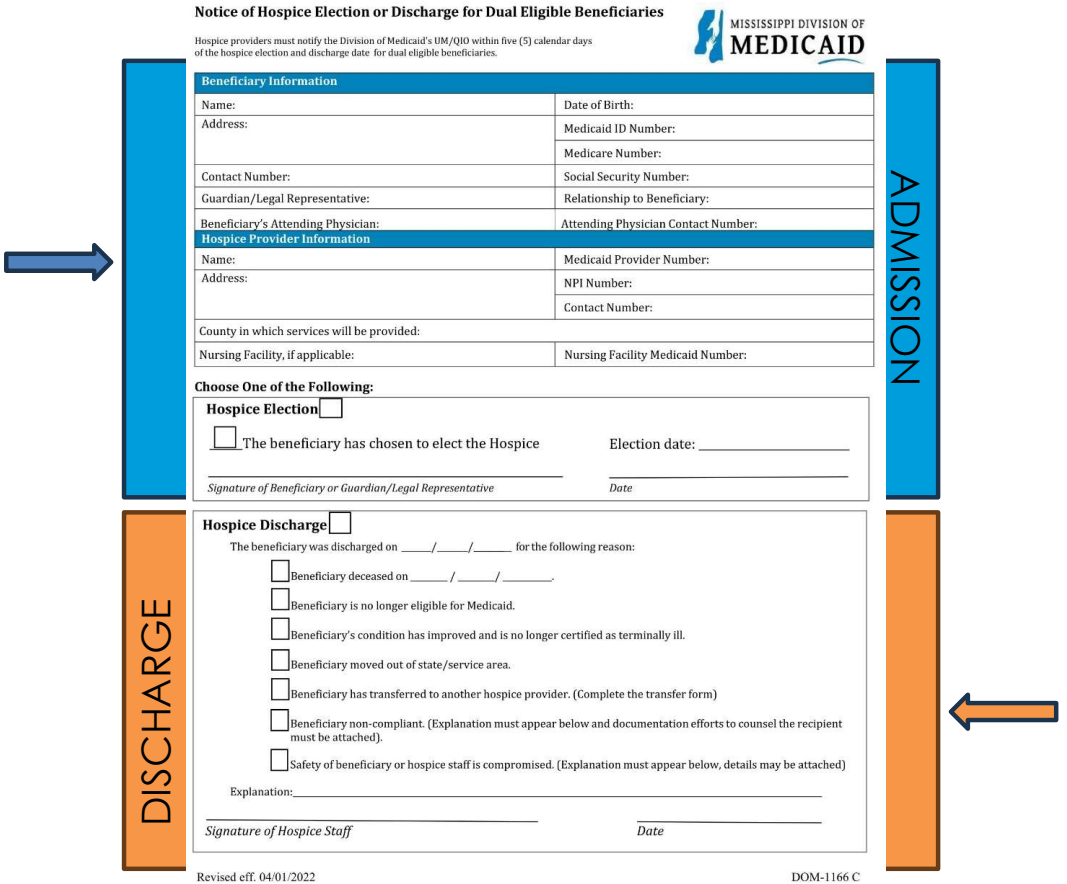
Name (print) _____ Signature _____ Date/Time _____

Revised eff. 04/01/2022 DOM 1165 C

Required Documentation: Dual Eligible Members

- This form is required by the Mississippi Division of Medicaid to notify of a hospice election or discharge for dual-eligible beneficiaries. Submit this form to Medicaid's UM/QIO within **five (5) calendar days** of the election or discharge date.
- Admission
  - The upper part of Form 1166c should be used for the Admission Hospice Election and when then beneficiary is being discharged.
  - Keep this form on record until discharge
- Discharge

  When the member is discharging, use the same form originally submitted and complete the bottom section and include with the discharge paperwork



Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries

MISSISSIPPI DIVISION OF MEDICAID

Hospice providers must notify the Division of Medicaid's UM/QIO within five (5) calendar days of the hospice election and discharge date for dual eligible beneficiaries.

ADMISSION

Beneficiary Information	
Name:	Date of Birth:
Address:	Medicaid ID Number:
	Medicare Number:
Contact Number:	Social Security Number:
Guardian/Legal Representative:	Relationship to Beneficiary:
Beneficiary's Attending Physician:	Attending Physician Contact Number:
Hospice Provider Information	
Name:	Medicaid Provider Number:
Address:	NPI Number:
	Contact Number:
County in which services will be provided:	
Nursing Facility, if applicable:	Nursing Facility Medicaid Number:

Choose One of the Following:

Hospice Election ☐

☐ The beneficiary has chosen to elect the Hospice — Election date: _____

_____ _____

Signature of Beneficiary or Guardian/Legal Representative — *Date*

DISCHARGE

Hospice Discharge ☐

The beneficiary was discharged on _____/_____/_____ for the following reason:

- ☐ Beneficiary deceased on _____/_____/_____.
- ☐ Beneficiary is no longer eligible for Medicaid.
- ☐ Beneficiary's condition has improved and is no longer certified as terminally ill.
- ☐ Beneficiary moved out of state/service area.
- ☐ Beneficiary has transferred to another hospice provider. (Complete the transfer form)
- ☐ Beneficiary non-compliant. (Explanation must appear below and documentation efforts to counsel the recipient must be attached).
- ☐ Safety of beneficiary or hospice staff is compromised. (Explanation must appear below, details may be attached)

Explanation: _____

_____ _____

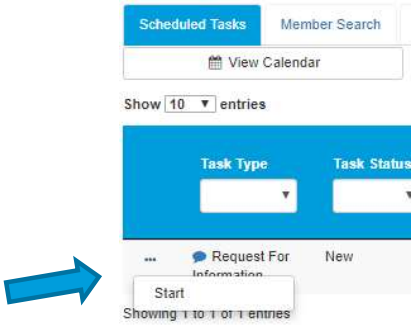
Signature of Hospice Staff — *Date*

Revised eff. 04/01/2022 DOM-1166 C

Request for Information

Request for Information

- When a reviewer needs additional clinical documentation to decide, the provider will be notified that additional Information is needed.
- Notification Methods:
  - Email to user that they have a request for more information
  - A task will populate in the Qualitrac system
- User steps:
  - Log into Qualitrac
  - Proceed to scheduled tasks
  - Click on the ellipsis to the left of the page, to start the task.



Provider Timeframes

- Providers have 10 business days to respond to a request for information (RFI).

The Telligen portal is available 24/7/365, except for scheduled maintenance days.

Request for Information

- Scroll down the **summary page** of the review
- Proceed to the correspondence section.
- Click on the blue name of the letter to open it and see what information is being requested.



Request for Information

- Scroll up to the **Documentation panel** to attach additional information.
- Click on the Add button-to attach additional clinical documentation to the review.



Request for Additional Information

- Once you add all necessary information, the system will trigger a task for the reviewer

- Once you have added the additional information, the system will return you to the Scheduled tasks queue and the task will no longer be visible for the user.

- ****Do NOT start a new review** to submit additional clinical information that was requested. This will delay the response. Please follow the steps outlined when a Request for Information task is available in the task queue.

Requesting a Continued Stay Request (CSR)

Requesting a CSR for Subsequent Election Periods

Providers must submit a Continued Stay Review (CSR) request **at least five (5) calendar days prior** to the end of the current election period.

This requirement applies to:

- Any subsequent **ninety (90) day election periods**
- Any subsequent **sixty (60) day hospice election periods**

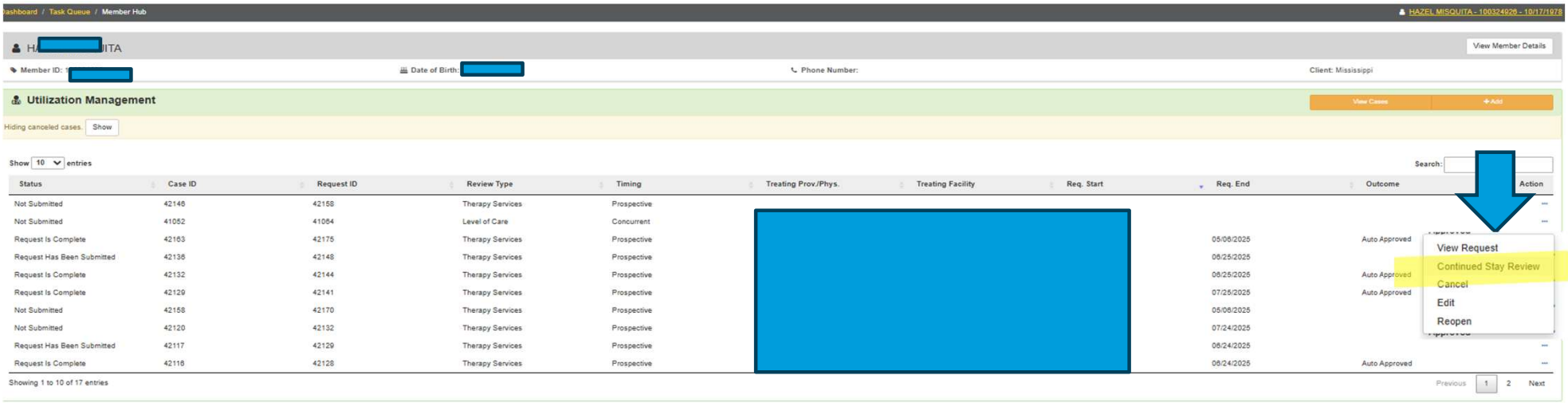
Process Change:
If you submit a new case instead of a CSR, the request will result in an **ONR (Outcome Not Rendered) outcome**, and the Reviewing Clinician (RC) will instruct you to submit the CSR under the current case.

Requesting a Continued Stay Review

1. **Select the Review Case:**
   - Locate the patient's **existing case ID**.
   - Click on the **blue ellipsis menu** next to the case.
   - Select **"Continued Stay Review."**
2. **Update Required Information:**
   - **Admission & Discharge Panel:** Confirm or update admission and anticipated discharge dates.
   - **Diagnosis Panel:** Add any new diagnoses that support the need for extended care.
   - **Documentation Panel:** Attach supporting medical records, physician notes, and other required documents.
3. **InterQual Criteria Documentation:**
   - Complete the **InterQual assessment** to document **medical necessity**.
   - If InterQual criteria do not apply, provide a written justification for the extended stay.

Request for Continued Stay

- From the Member Hub, under UM Panel, locate the case you would like to request an extension for DOS



Discharge Task

Discharge Submission

After hospice services have ended, providers are required to notify the Division of Medicaid of the discharge.

Per Mississippi Medicaid policy: "The hospice provider must notify the Division of Medicaid of any discharge by filing a discharge notice within five (5) calendar days after the effective date of discharge."(Source: Rule 1.4.H, Title 23, Part 205)

Additionally, providers must complete the Discharge Task in Qualitrac within **ten (10) calendar days** of the discharge date to ensure accurate recordkeeping and compliance.

When a Discharge Notice is Required

Acceptable Discharge Reasons Include:

- Beneficiary moved out of the hospice service area
- Beneficiary is no longer terminally ill (condition improved)
- Discharged for cause (must be clearly documented and approved)

Key Reminders

- All discharges must be documented in the medical record
- Failure to submit a discharge within 5 days may impact future authorizations and Medicaid compliance
- Ensure discharge date and disposition are accurate in the portal

Instructions for Submitting a Discharge in Qualitrac

1.From the Home Screen:

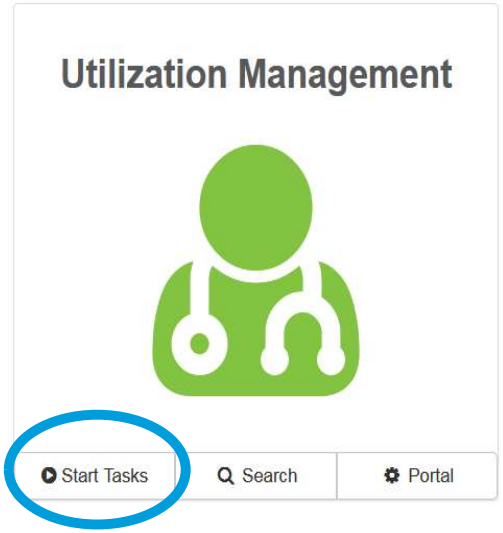
1. Navigate to the **Utilization Management** section.
2. Click on **Start Task**.

2.Search for Your Case:

1. Under **Case ID** column, enter your **Case Number** and press **Enter**.

3.Open the Case:

1. Click the blue **ellipsis menu** (three dots) next to the case.
2. Select **Start** to open the case.



Discharge Information Task

Filtered Scheduled Tasks

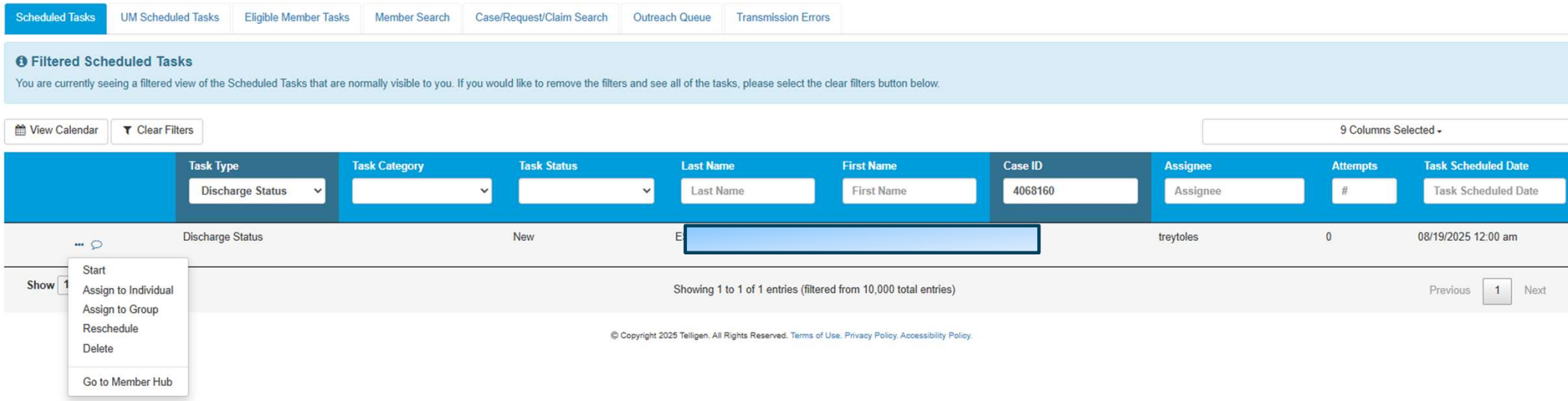
You are currently seeing a filtered view of the Scheduled Tasks that are normally visible to you. If you would like to remove the filters and see all of the tasks, please select the clear filters button below.

View Calendar | Clear Filters | 9 Columns Selected

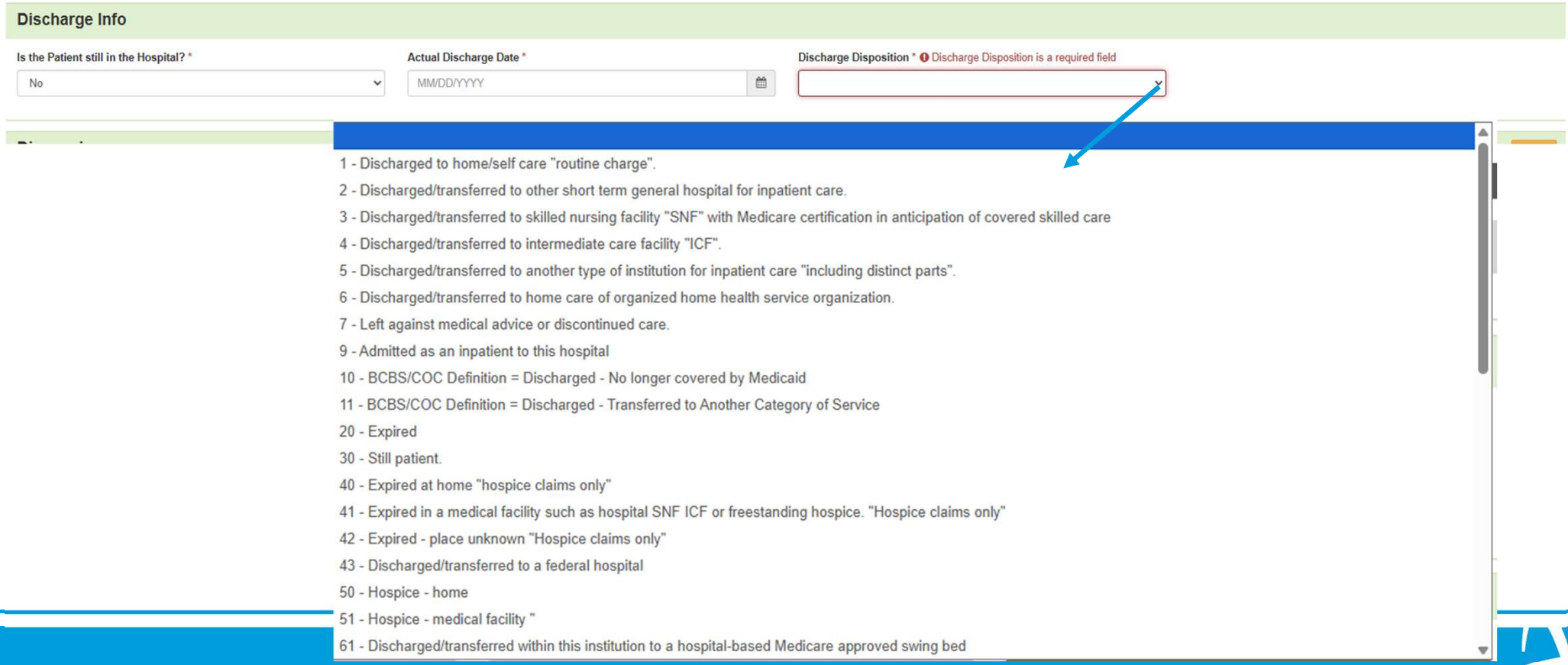
	Task Type	Task Category	Task Status	Last Name	First Name	Case ID	Assignee	Attempts	Task Scheduled Date
				Last Name	First Name	Case Id	Assignee	#	Task Scheduled Date
···	Discharge Status		In Progress	JACKSON	BA		ins	0	06/16/2001 12:00 am
···	Discharge Status		In Progress	JONES	FL		ins	0	06/16/2001 12:00 am
···	Discharge Status		In Progress	SHELTON	AA		n24	0	12/30/2001 12:00 am
···	Discharge Status		In Progress	EDWARDS	JA		s	0	03/19/2002 12:00 am
···	Discharge Status		In Progress	WOODARD	GL		ins	0	05/27/2002 12:00 am
···	Discharge Status		In Progress	CAVETT	JA		er	0	02/10/2003 12:00 am
···	Discharge Status		New	SHANDS	WI		ins	0	09/24/2003 12:00 am
···	Discharge Status		In Progress	WILLIAMS	JO		ins	0	04/05/2004 01:00 am
···	Discharge Status		In Progress	MOSS	SU		ins	0	04/16/2004 12:00 am
···	Discharge Status		New	ANGLIN	JA		er	0	09/29/2004 12:00 am

Show 10 entries | Showing 1 to 10 of 10,000 entries | Previous 1 2 3 4 5 ... 1,000 Next

Discharge Information Task

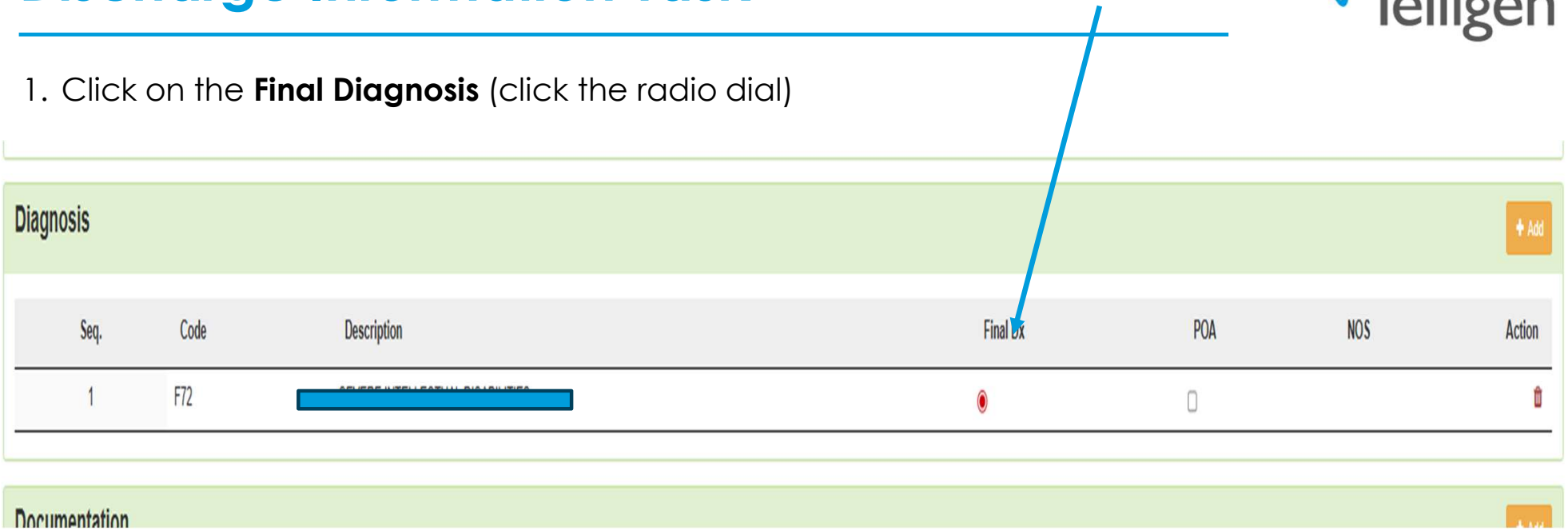


Discharge Information Task



Discharge Information Task

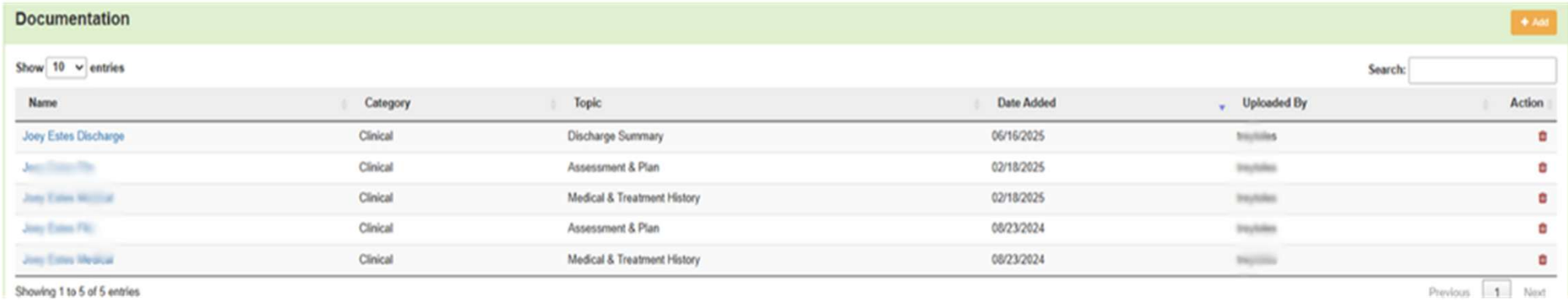
1. Click on the **Final Diagnosis** (click the radio dial)



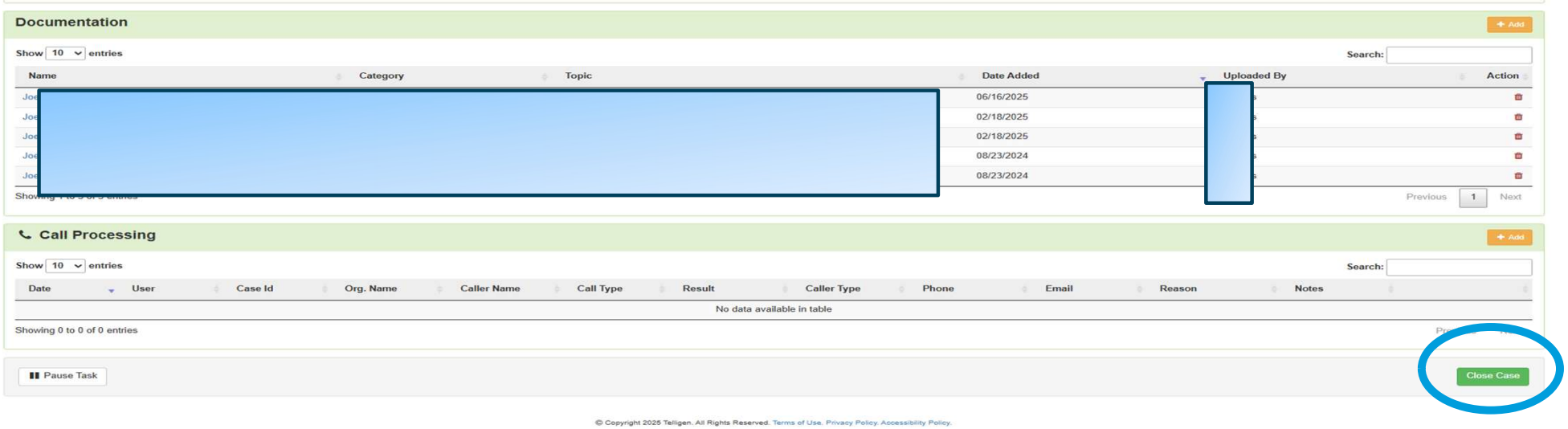
Discharge Documentation

- **Discharge Documentation**
  - The completed Discharge disposition that includes the date of discharge
  - DOM Form 1166A or 1166C

- **Discharge Orders**
  Medications, treatments, procedures Dated and Signed



Steps to complete the Discharge Process:



1. Scroll to the **Discharge Disposition** section and make your selection.
2. Click on the **Final Diagnosis** (click the radio dial)
3. Upload your **Discharge Paperwork**.
4. Scroll to the bottom of the page and click **Close Case** to complete the submission.

Timeliness Submission

Timing Types for Hospice Authorization

Prospective: Before services begin. Providers should submit authorization request prior to admission within five **(5) calendar days** of admission date.

Concurrent: During active service. Providers should submit a concurrent request within five **(5) calendar days prior** to the end of the current election period.

Discharge: After services are complete. Per MS DOM, the hospice provider must notify the Division of Medicaid of any discharge by filing a discharge notice within **five (5) calendar days** after the effective date of discharge." (Source: **Rule 1.4.H**, Title 23, Part 205) Providers must complete the discharge task in Qualitrac within ten **(10) calendar days after** the discharge date.

Submitting Change Request

What is a Change Request?

A **Change Request Form** is used to request **simple modifications** to a **previously approved** prior authorization (PA). It is **not** intended for:

- Reconsiderations or appeals of denied claim (including tech denials)
- Submitting new election periods
- Extending beyond current lock-in
- Updates to claims that have already been paid

Timeframe for Submission

- Submit the Change Request within 90 days of the PA approval date listed in your decision letter.
- Change Request should be faxed 800-524-5710 or email: MSMedicaidUM@Telligen.com

  Make sure to include any relevant documentation supporting your request

Key Reminders

- A denied PA requires a reconsideration, not a change request.
- A paid PA cannot be modified—void the claim first.
- Ensure the form is signed, dated, and submitted within the 90-day window.

When to use a Change Request

Scenario	Is Change Request Appropriate?	Required Action	Notes
Update minor data entry errors	Yes	Submit Change Request Form	Cannot extend beyond current lock-in
Correct diagnosis code	Yes	Submit Change Request Form	Provide correct diagnosis with justification
Change NPI or place of service	Yes	Submit Change Request Form	MANUAL UPDATE REQUIRED: Ensure accuracy to avoid denial
Denied authorization	No	Submit Reconsideration Request	Use the Appeals process
More than 90 days since approval	No	Contact Telligen	MANUAL UPDATE REQUIRED: Changes not accepted after 90 days
Extend Dates of Service	No	Submit a Concurrent Review	Submit before current auth expires

Appeal Rights & Submission Process

Appeal Rights & How to submit Appeal Levels

When a review has a determination of denied or partial denial, the provider can submit an appeal. The provider will have 30 calendar days from the date of outcome letter to submit the request.

- **1st level** – Submit a reconsideration request via Qualitrac
- **2nd level-** Request a Peer-to-Peer with a Telligen MD
- **3rd (final**) – Submit a written request for Administrative Appeal with DOM

Appeal Rights & How to submit Appeal Levels

Appeal Level	Submission Method	Key Details Required	Submission
1st Level	Qualitrac Portal	Case # or Member ID + Upload additional documentation	Use Qualitrac
2nd Level	Peer-to-Peer (P2P)	Call or email with: Case #, physician info, contact #, and availability	1-855-625-7709 msmedicaidum@telligen.com
3rd Level	Written Administrative Appeal	Submit written request by mail (include case # and documentation)	Division of Medicaid Attn: Office of Appeals 550 High Street, Suite 1000 Jackson, MS 39201

FAQ's, Helpful Links & Survey

Helpful Links

Education/Training

https://msmedicaid.telligen.com/education-training/

Document Library

https://msmedicaid.telligen.com/document-library/

- Hospice Election Notice Form
- Hospice Revocation Discharge Form (Medicaid Only)
- Hospice Physician Certification Recertification Form
- Hospice Election or Discharge for Dual Eligible Beneficiaries
- Hospice Transfer Form

Helpful Tips

- **Complete Documentation**: Include comprehensive clinical details. Ensure all signatures are on required documentation
- **Effective Communication**: If additional information is required, respond promptly via the portal under **Request for Information (RFI)** to prevent delays in approval.
- **Medicaid Provider Number**: If you search with the Medicaid Provider Number, that will ensure you are selecting the correct doctor and location.

Contact Us

Education Manager – Primary Point of Contact
Charity A Jones chjones@telligen.com
Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk
- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions
- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager
Claudia Collins

Assistant Program Manager
Cassandra Bullock

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Book 1 on 1: [Book with Charity]

SURVEY

https://www.surveymonkey.com/r/NY3QPZJ