Mississippi Medicaid:

Telligen Provider Review Training
Molecular (Genetics) Testing

December 2025

© 2020, Telligen, Inc.

Agenda

- Agenda
- Contact Information
- Submitting A Review
- InterQual
- Request for Information
- Change Request
- Appeals
- Website Tour
- Care Management
- Q&A

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

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: 855-625-7709

Program Manager

Claudia Collins

Assistant Program Manager

Cassandra Bullock

Submitting a Review
Understanding Key Terms & Processes

Telligen Provider Portal – Required sections

The following panels will be required for your request:

- **Authorization Request Type**
  - **Place of Service**
  - **Request Timing**
- **Dates of Service**
- **Coverage**
- **Supporting Information**
- **Providers & Provider Organization Visibility**
- **Diagnosis ,Procedures & Modifiers**
- **Documentation**
- **InterQual**

Review Timings

- **Prospective:** Review submitted **before** services begin, covering future dates of service.
- **Concurrent:** Initial review for services that are **already in progress**.
  - Covers a defined date span under a single authorization
  - Applies to ongoing admissions or services
- **Retrospective:** Used when services were provided **before** the authorization request due to a change in coverage.
  - The member must be determined **retroactively eligible**
  - Both the start date and end date must occur **before** the request submission date

Key Reminder
The review timing selected in Qualitrac must reflect **when the services were or will be provided**, not the submission date alone.

Retrospective Review Window

Retrospective Review Window– A review process used for genetic testing authorization requests when the specimen has already been collected prior to submitting the prior authorization.

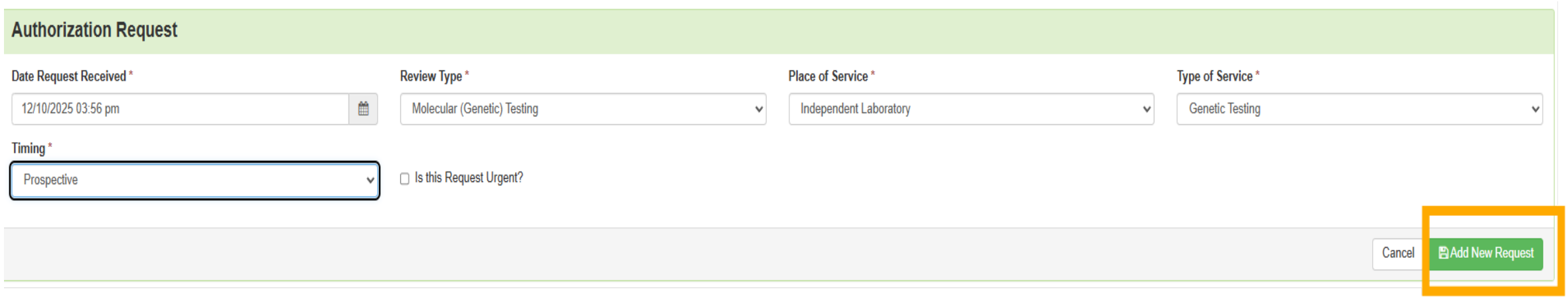
- Providers must select **Retrospective timing** in this scenario
- The date of service must be within 15 business days of the specimen collection date
- This requirement applies regardless of retro-eligibility status

Key Reminder- The review timing selected in Qualitrac must reflect when services were or will be provided, not the submission date alone.

Authorization Request Panel- Review Type

Authorization Request Panel – Review Type

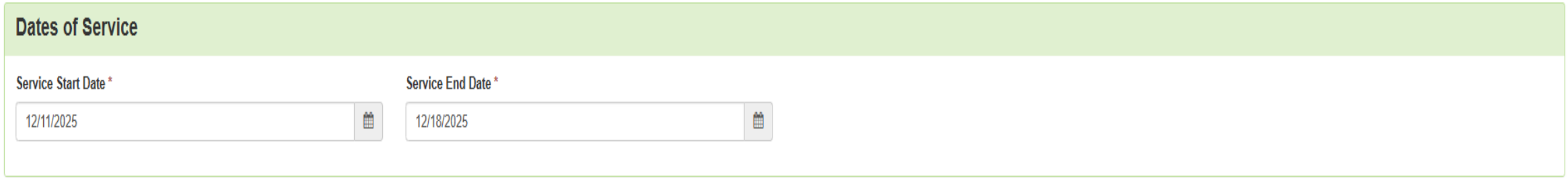
- Enter the **Date Request Received** using the date the request was submitted
- Select **Molecular (Genetics) Testing** as the Review Type
- Select **Independent Laboratory** as the Place of Service
- Select **Genetic Testing** as the Type of Service
- Select the appropriate **Timing** (Prospective or Retrospective)
- Confirm all required fields are completed before proceeding
- Select **Add New Request** to continue building the authorization request



Date of Service Panel

Ensure the date span accurately reflects the service timeline submitted for review.

- Select the **Service Start Date** using the **date of specimen collection**.
- Select the **Service End Date** using the **date the lab results were finalized**.



Common Errors to Avoid:

- Do not use the order date or billing date as the service start date.
- Do not enter the same date for start and end unless the specimen collection and lab results occurred on the same day.
- Do not extend the date span beyond the actual testing timeline.

Adding Coverage

Verifying Eligibility

Why Eligibility Verification Matters

- Confirms active Medicaid coverage for the date of service
- Helps avoid denials by ineligibility or coverage lapses
- Provides important details on benefit plans, managed care assignments, and any limitations.

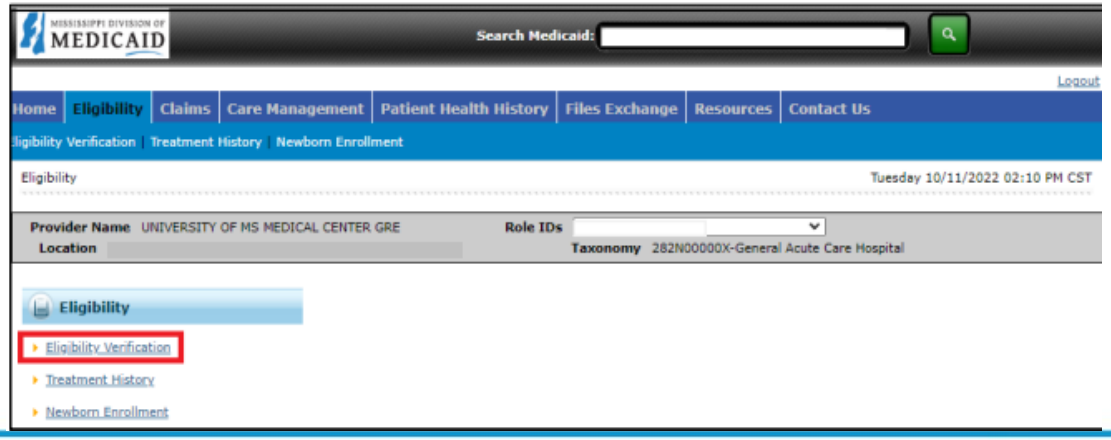
Key Takeaways

- Always verify eligibility **before** submitting a Prior Authorization request.
- Always verify eligibility **before** providing services.

Resources

- Eligibility Verification
- MESA Portal for Providers
- Eligibility, Benefit Usage, and Retro Job Aid





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 Retro Eligibility

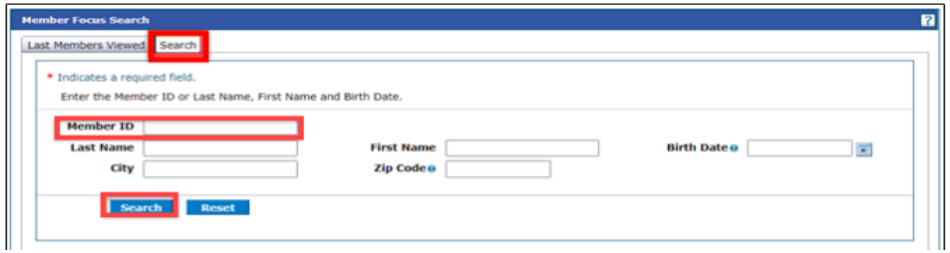
1. To view Retro Eligibility, log into the provider portal and select **Member Focused Viewing**, located on the bottom left side of the home page.

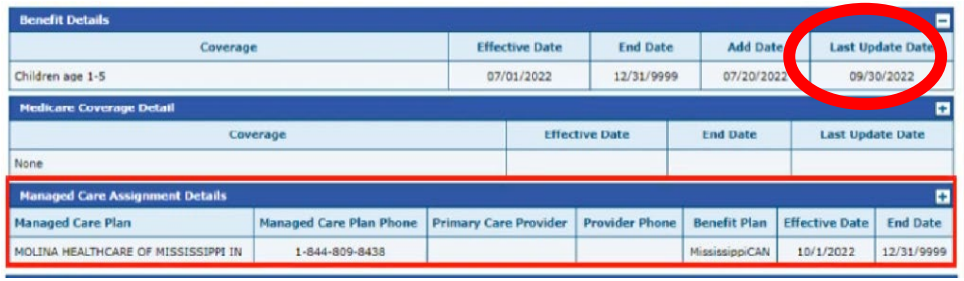
2. Select the **Search** tab, enter the Member ID (and any additional information if needed), then select **Search**.

3. The results page will display the member's demographics, the **original effective date**, any **retroactive add dates**, and the **end date of coverage**. The **Last Update Date** helps determine the retro eligibility period.

Policy Reminder Per Mississippi Medicaid Administrative Code Title 23, Part 200, Rule 1.8:
Claims denied for untimely filing may only be reviewed if the member has retroactive eligibility **and** the required prior authorization (when applicable) was obtained **within 90 days of the eligibility last updated date**.







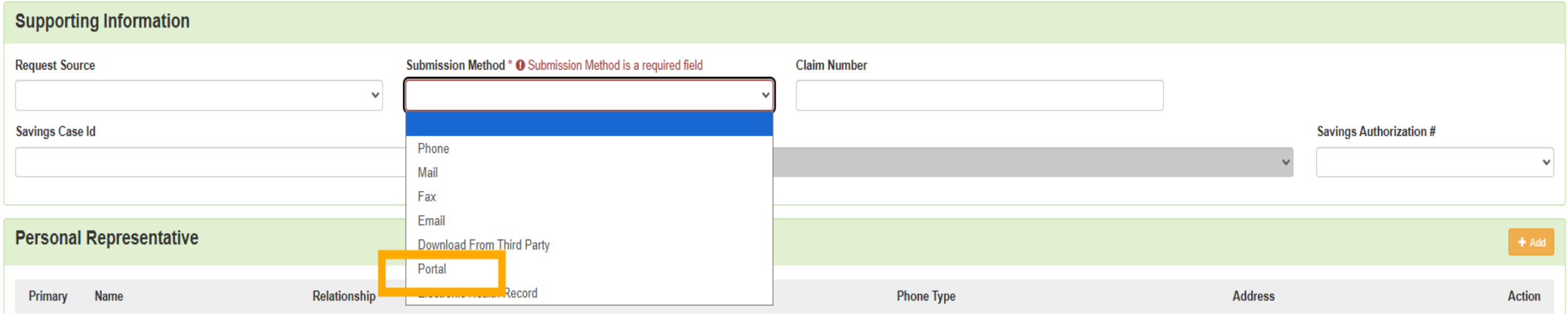
Timely filing requirements depend on whether the date of service occurred **before or after** the last update date.

Supporting Information

Supporting Information Panel

This section captures how the authorization request is submitted. Requests submitted through Qualitrac must be identified as **PORTAL** submissions.

Submission Method
– Select **PORTAL** from the dropdown menu.

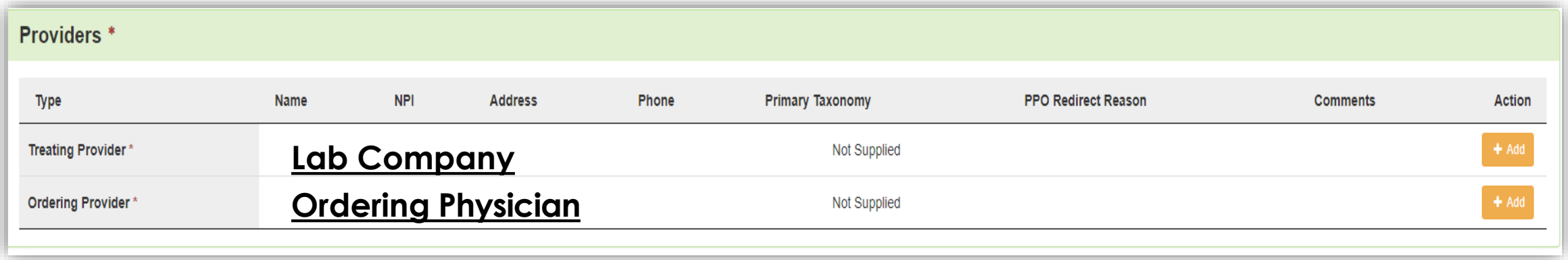


Providers

Providers Panel: Physician and Provider Information

This section requires information identifying who is ordering and who is providing the service.

- Treating Provider: This will always be the **Independent Laboratory** performing the genetic testing.
- Ordering Provider: This will always be the **Physician** who ordered the laboratory tests.

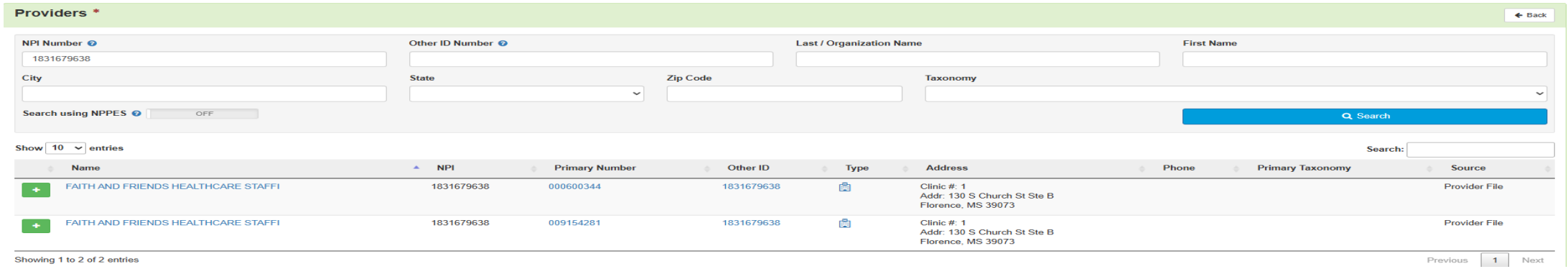


Select **Add** in each row to enter the required provider details, including NPI and address information.

Entering Physician and Facility Information by NPI

Select **Add** to open the provider search window. Search for the provider or facility by entering one of the following:

- **NPI number**
- Select **Search** to display matching results.



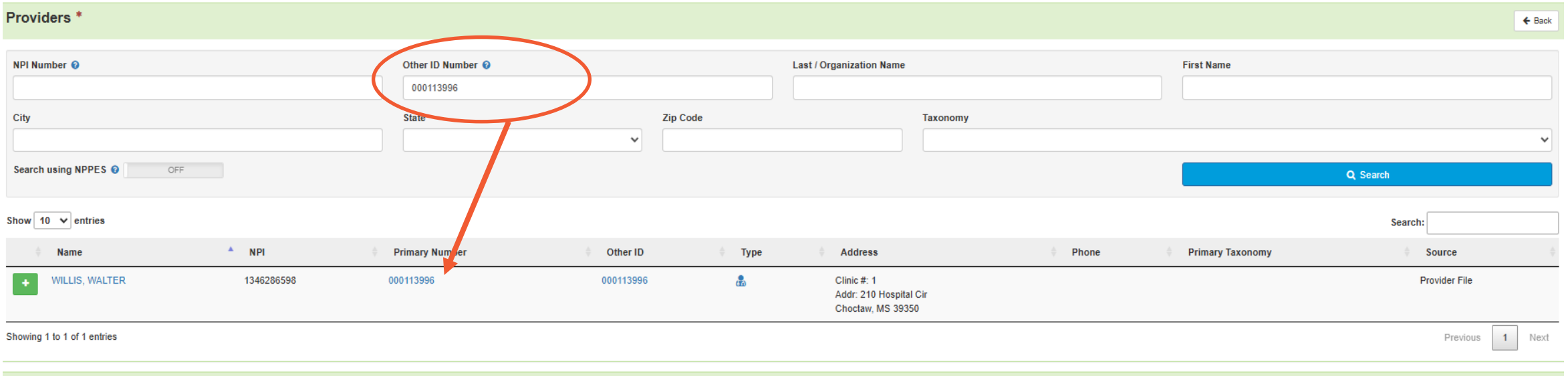
- Verify the provider's name, address, and Medicaid Provider ID is correct before selecting

	Name	NPI	Primary Number	Other ID	Type	Address	Phone	Primary Taxonomy	Source
+	JACKSON, ALLEN		000126363	000126363		Clinic #: 1 Addr: 2351 Highway 1 S Greenville, MS, 38701	(662) 344-1817	General Practice	Provider File

- Click the + to add appropriate provider from the list.

Entering Physician and Facility Information by Medicaid Provider ID

- Select **Add** to open the provider search window.
- Enter **Medicaid Provider ID** (entered in the Other ID Number field),
- After entering the information, select **Search** to locate the correct physician or facility.
- Click the  to add appropriate provider from the list.



Best Practice Reminder: When possible, use the Medicaid Provider ID for the most accurate match, especially when multiple locations or NPIs exist for the same provider.

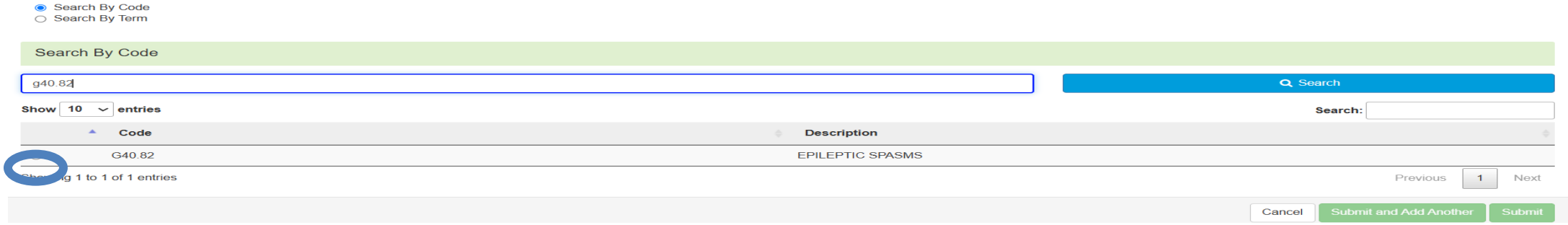
Diagnosis, Procedure Codes and Modifiers

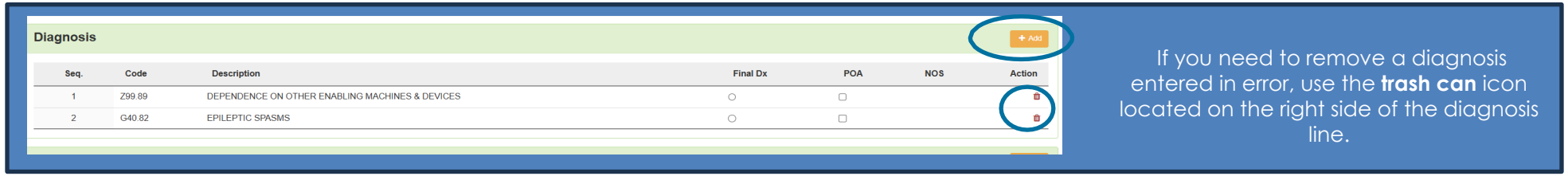
Diagnosis Panel

Select **Add** to open the diagnosis search window. You can search for a diagnosis using either:
Code (ICD-10 code), or **Term** (diagnosis description)

Steps to Search

1. Select the search method (Code or Term) using the radio button.
2. Enter the diagnosis code or keyword in the search box.
3. Click **Search**.
   - Select the correct diagnosis by clicking the radio button to the left of the code.
   - Click **Submit** (or **Submit and Add Another** if multiple diagnoses must be entered).



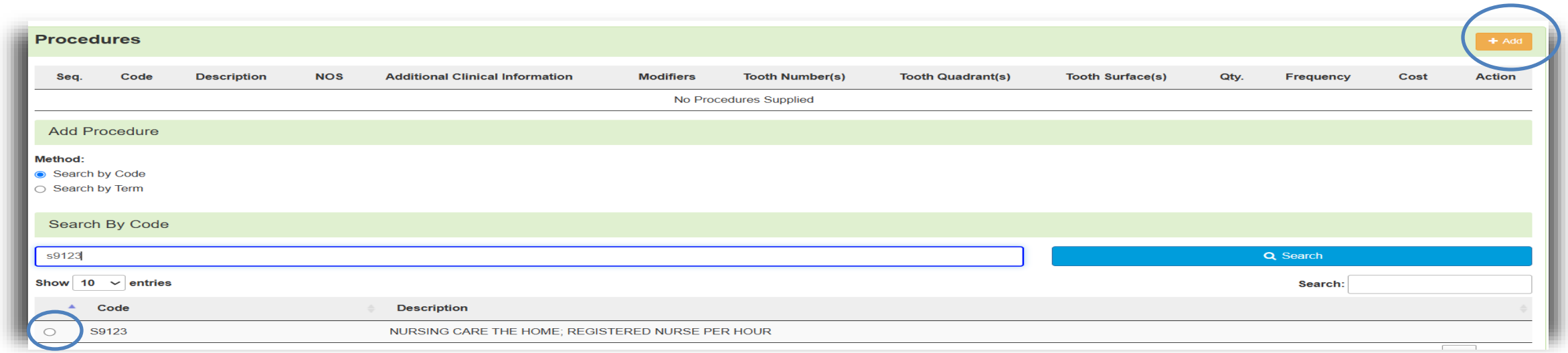


Procedure(s) Panel

The Procedures Panel is where you will enter the procedure code information required for this review. Select **Add** to open the procedure search window.

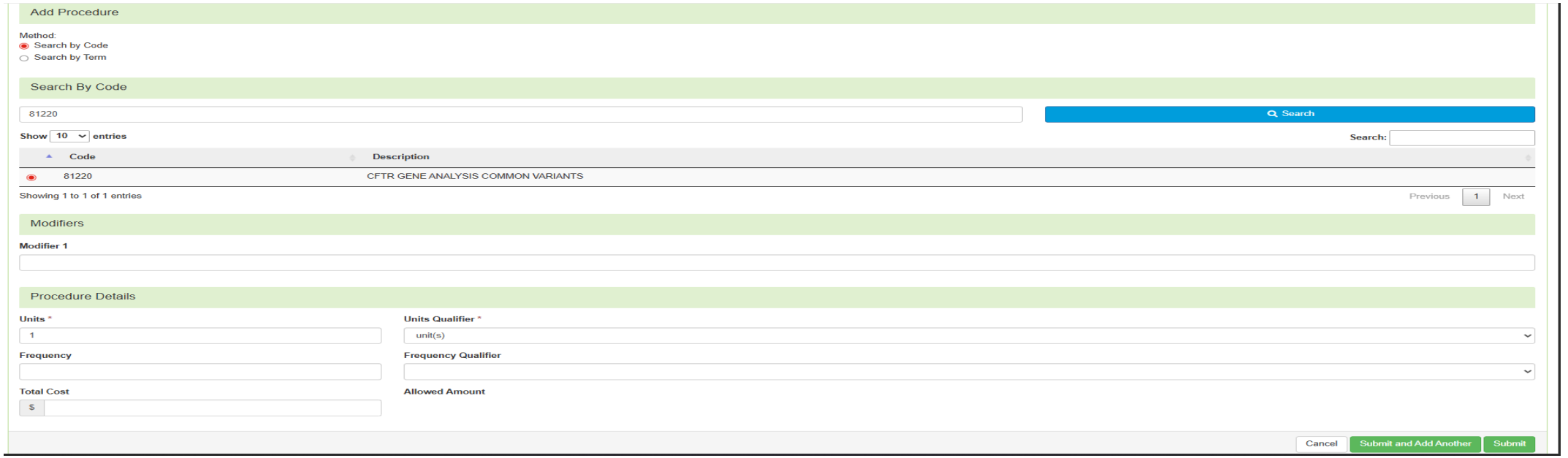
Steps to Search

1. Select the search method (Code or Term) using the radio button.
2. Enter the procedure code or keyword in the search box.
3. Click **Search**.
   - Select the correct procedure by clicking the radio button to the left of the code.
   - Click **Submit** (or **Submit and Add Another** if multiple procedure (s) must be entered).



Modifier(s)

Once the system populates the procedure code results, use the radio button to select the correct procedure. After selection, the Modifiers section becomes available for completion.



Modifiers are **not always required** in Qualitrac. However, if the claim will be billed with a modifier based on coding guidelines and/or billing practices, the prior authorization must reflect the **same modifier(s)**. The PA should always match how the claim will be billed.

Documentation

Genetics Testing Criteria

The Division of Medicaid defines genetic testing as a type of analysis that identifies changes in chromosomes, genes, or proteins that confirms or rules out a suspected genetic condition.

The Division of Medicaid covers genetic testing when medically necessary to establish a diagnosis of an inheritable disease only when **all** the following are met:

1. The beneficiary displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic),

2. The result of the test will directly guide the treatment being delivered to the beneficiary, and

3. After history, physical exam, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

Source: MS Administrative Code Title 23: Division of Medicaid Part 219: Laboratory Services Part 219 Chapter 1: General Rule 1.9: Genetic Testing

Clinical Documentation Criteria

✅ Do
Document **diagnosis + onset + clinical presentation**
Provide **labs, vitals, imaging, response to treatment**
Show **why current level of care is required**
Update records **daily** for inpatient/concurrent reviews
Include **functional limitations or safety risks**
Match documentation to **review criteria (InterQual)**

Clinical information must be documented in office visit notes or other medical record documentation such as:

- x-ray results
- diagnostic imaging or testing reports, or other
- Physician referral documentation.

Handwritten notes on cover sheets, telephone calls, or other fax pages that are not reflected in office visit notes will not constitute actionable information for clinical decision making.

All documents must include:
Two beneficiary identifiers (e.g., Name + DOB)

Required Documentation

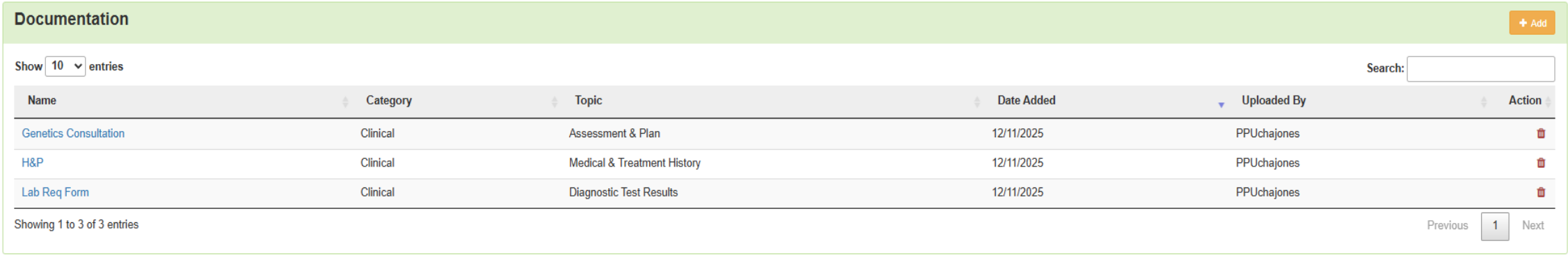
- Completed Lab Requisition Form: Signed by Ordering Physician
  - Specific genetic test name, unique test ID, CPT/HCPCS codes for the procedure, and lab's NPI/CLIA numbers
- Clinical Justification:
  - Documentation demonstrating medical necessity, explaining how the test results will guide treatment decisions
  - Other pertinent clinical documentation (if requested)
- Lab Results: Relevant prior lab work
  - Pedigree Chart: A multi-generational family history showing inheritance patterns, (if applicable).
  - Results and/or reports of prior genetic test(s)(related to the condition)
- Clinical Notes:
  - Relevant H&P (History & Physical)
  - Progress notes (within 6 months)
  - Genetics consultation notes (if applicable)
  - Documented Gestation (if applicable, a minimum of 10 weeks gestation)

Documentation Panel

Use this panel to upload all required documents that support the prior authorization request (e.g., Plan of Care, Medical Necessity forms, clinical notes, lab orders).

- Select **Add** to upload a new document.
  – Choose the **Category** and **Topic** from the dropdown menus.
  – Upload the file and verify it appears in the list once saved.
- Review the documentation list to ensure all required items are attached.
  – The **trash can** icon may be used to remove any document uploaded in error.

Once all documents are uploaded, select **Continue** to proceed with the next section of the review.



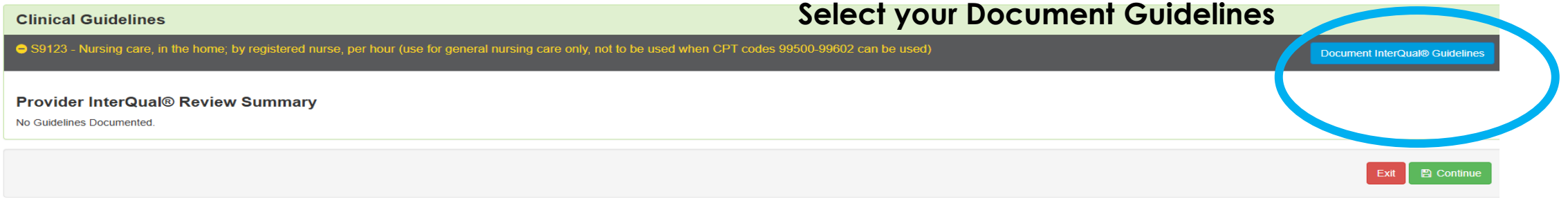
InterQual

Purpose of InterQual

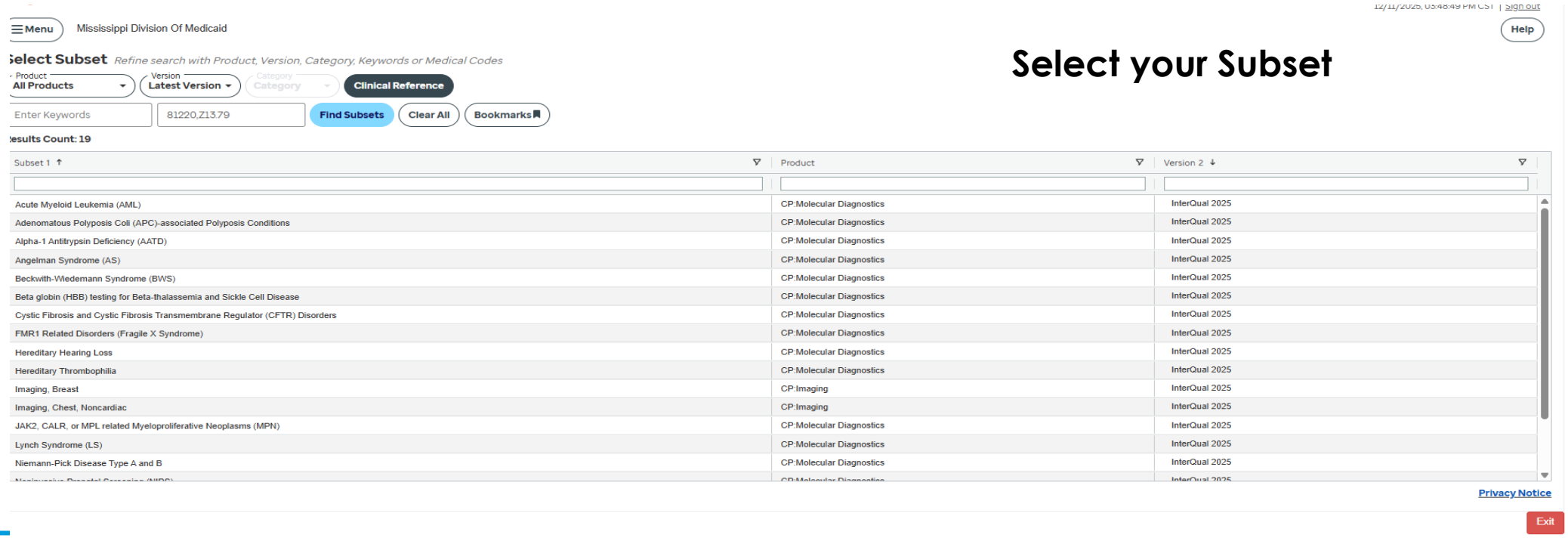
Purpose	Description
Standardize clinical review	Ensures decisions are based on current, consistent clinical evidence
Support medical necessity determinations	Helps determine if the requested service level aligns with best practices
Guide reviewers and providers	Gives a shared framework to submit and review clinical documentation
Improve utilization and reduce overuse/underuse	Promotes appropriate care and resource use

InterQual Process

Select your Document Guidelines



Select your Subset



InterQual Process

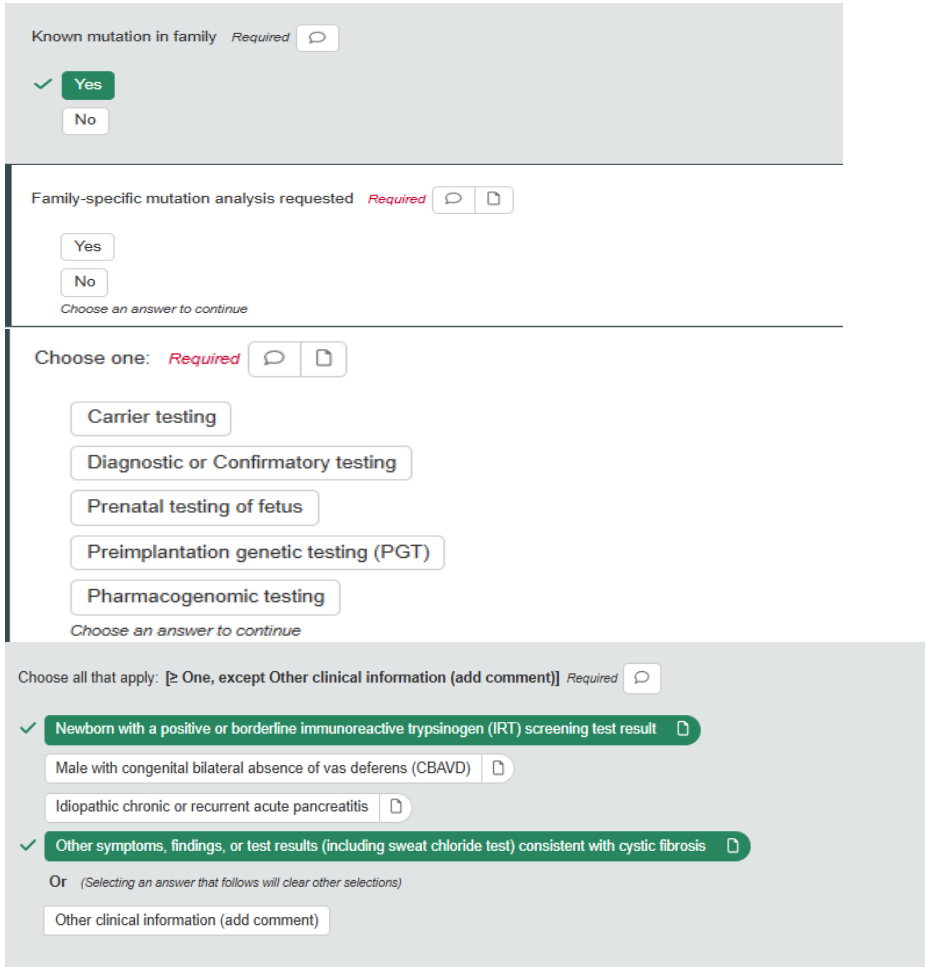
Review each InterQual question carefully and select the criteria that apply.

Your selections must align with the clinical documentation provided to support medical necessity.

- Read each question and choose the most accurate option based on the member's clinical presentation.
- For subset questions, select **Yes** or **No** according to the supporting clinical records (e.g., lab results, genetic reports, history, symptoms).
- When prompted to "Choose one" or "Choose all that apply," ensure your selections match the clinical indications documented in the submitted materials.
- Use the **Other clinical information** comment box when additional clarification is required.

Key Reminder

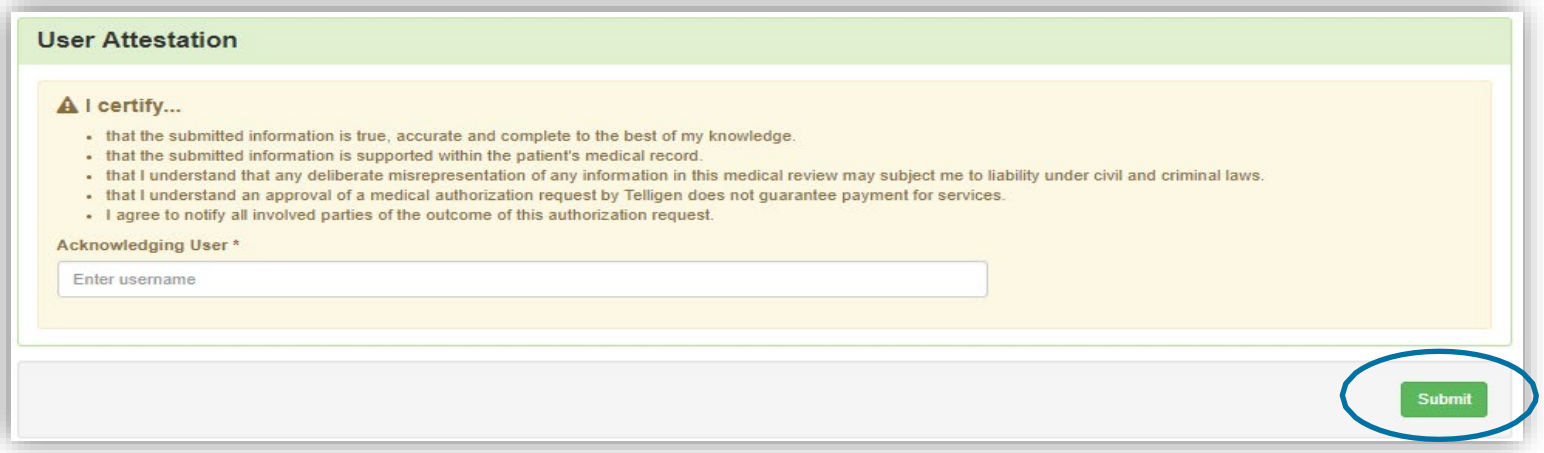
InterQual responses must be fully supported by clinical documentation. Selections inconsistent with the provided records may result in delays, RFIs, or non-approval.

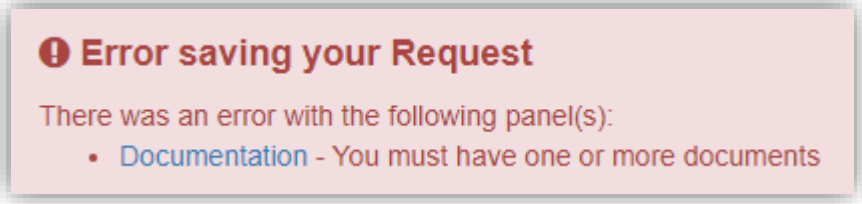


Attestation

The final step of the submission process is completing the **Attestation** section.

- Enter your **Username** in the attestation field to certify that the information submitted is accurate and complete to the best of your knowledge.
- Select **Submit** to send the review to Telligen for processing.

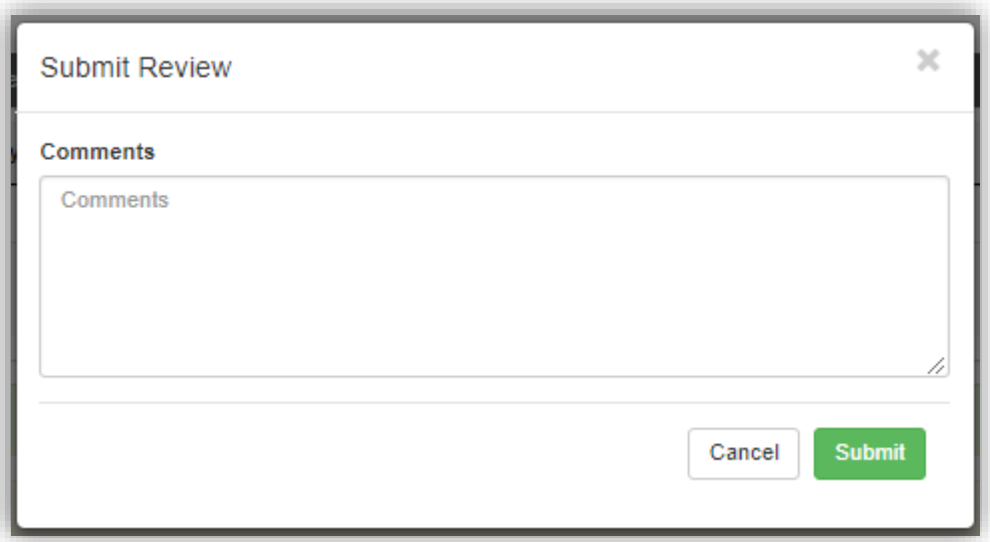




The request cannot be submitted until all required fields and documents are completed and the attestation is entered. If any required information is missing, the system will display an error message identifying the section that needs attention (for example, missing documentation)

Comments

- Users have the option to add comments to the review before it is sent to Telligen.
- A comments modal will open, and the user can enter additional information related to the review.
- **This is not required to complete the review**.



Request for Information

Request for Information (RFI)

When a reviewer requires additional clinical documentation to make a determination, the submitter will be notified that more information is needed. Providers have **10 business days** to respond to a Request for Information (RFI).

Notification Methods (Portal Users)

- An email notification will be sent indicating that additional information is required.
- An RFI task will populate in the Qualitrac system.

RFI Task Process

- Once you add all requested information, the system will automatically trigger the task back to the reviewer.
- After submission, you will be returned to the Scheduled Tasks queue and the RFI task will no longer be visible to the user.

Important Reminder

- **Do NOT start a new review** to submit additional information that was requested.
- Always respond using the **RFI task** available in the Scheduled Tasks queue.

Request for Information (RFI)

User Steps

1. User Steps
2. Log into **Qualitrac**
3. Search by **Member ID**
4. From the Member Hub, scroll to **Utilization Management**
5. Locate the case in **RFI status**
6. Click the **blue ellipsis (…)**
7. Select **View Request**
8. From the case summary page, scroll to **Correspondence**
9. Click the blue **Request for Information** letter
10. Review the **last page** of the letter for requested items
11. Upload **all requested documentation** under the **Documentation Panel**
12. Select **Done** to return the case to the reviewer

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). Change Requests must be submitted **within 90 days** of the PA approval date listed on the outcome letter.

Use a Change Request when:

- Date Corrections– A correction of **less than a 2-day difference** at the start or end of the approved certification period.
- Minor Administrative Updates (with supporting documentation), including:
  - Correcting provider information
  - Adding appropriate modifiers
  - Cancelling an approved PA request

Change Requests Are not Intended For:

- Adding or removing **CPT codes**
- Reconsiderations or appeals of denied claims (including technical denials)
- Updates to claims that have already been paid

Change Request should be faxed 800-524-5710 or email: MSMedicaidUM@Telligen.com

Appeal Rights and Submission Process

Appeal Rights for Technical Denials

When Telligen requires additional clinical information, a Request for Information (RFI) letter is issued to the provider. The provider has **10 business days** to submit the requested documentation.

If the provider does not respond within the allotted timeframe, the system will issue a **Technical Denial**. This means that Telligen is unable to establish medical necessity due to insufficient clinical documentation.

- **Reconsideration (1st Level Appeal)** – Providers have **10 business days** from the date of the Outcome Letter to submit a 1st level appeal.

  If the reconsideration is denied, **the determination is final for the provider.**

- **Administrative Appeal (Final) –** The beneficiary or the beneficiary's legal representative (which may also be the provider) has the right to request an Administrative Appeal through the Division of Medicaid within **30 calendar days** of the Outcome Letter.

Appeal Rights for Technical Denial Reconsideration

Appeal Level	Submission Methods	Key Details Required	Submission Timeline	Notes
Provider Reconsideration 1st Level Appeal	▪ Qualitrac Portal (http://myqualitrac.com) Fax or Mail (Alternate Option) ▪ **Fax**: 1-800-524-5710 ▪ **Mail**: Telligen 715 S Pear Orchard Rd, Ste 400, Ridgeland, MS 39157	▪ Case # ▪ Supporting documentation	Must be submitted within **10 business days** of the Outcome Letter	Once reconsideration is denied, the determination is **final for the provider**
Administrative Appeal Beneficiary or legal representative may file	**Mail**: Division of Medicaid Attn: Office of Appeals c/o Director of Appeals P.O. Box 2222 Jackson, MS 39225	▪ Case # ▪ Supporting documentation	Must be submitted within **30 calendar days** of Outcome Letter	Providers cannot request this level unless they are the legal representative.

Submitting a Reconsideration (1st Level Appeal)

- To submit a reconsideration for a denied review:
  - Go to the **UM panel** in the member hub
  - Click on the blue ellipsis within the denied case to open the action menu
  - Once there, select **1st Level Appeal** from the menu.



Appeal Rights for Med Nec (Clinical) Denials

Appeal Level	Submission Methods	Key Details Required	Submission Timeline	Notes
Provider Reconsideration 1st Level Appeal	▪ Qualitrac Portal (http://myqualitrac.com) Fax or Mail (Alternate Option) ▪ **Fax**: 1-800-524-5710 ▪ **Mail**: Telligen 715 S Pear Orchard Rd, Ste 400, Ridgeland, MS 39157	▪ Case # ▪ Supporting documentation	Must be submitted within **10 business days** of the Outcome Letter	If the reconsideration is denied, the case will be **automatically escalated to Peer Review** .The Peer Reviewer will issue the final provider-level determination: – **Approve** (overturn denial) – **Uphold** (deny) **The determination is final for the provider.**
Administrative Appeal Beneficiary or legal representative may file	**Mail**: Division of Medicaid Attn: Office of Appeals c/o Director of Appeals P.O. Box 2222 Jackson, MS 39225	▪ Case # ▪ Supporting documentation	Must be submitted within **30 calendar days** of Outcome Letter	Providers cannot request this level unless they are the legal representative.

Care Management Resources

Care Management

Primary Point of Contact
Jamela McInnis, Supervisor
1-866-938-5144 | jmcinnis@telligen.com

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

Target Populations:

Our program supports fee-for-service (FFS) beneficiaries with the following conditions:

- Hepatitis
- **HIV and AIDS**
- Hemophilia
- **Postpartum Mothers**
- Katie Beckett Program (KBP) formerly DCLH

Comprehensive Assistance:

- Navigating and coordinating services with multiple providers/agencies and establishing crisis plans.
- Developing individualized, person-centered care plans in collaboration with individuals, families, and medical providers.
- Monitoring ongoing services, progress toward goals, and the individual's well-being, health, and safety.

Website Tour & Survey

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: (855-625-7709

Program Manager
Claudia Collins

Assistant Program Manager
Cassandra Bullock

Contact Us

Education Manager – Primary Point of Contact
Charity A Jones chjones@telligen.com

Book 1 on 1: [Book with Charity]

SURVEY

