Mississippi Medicaid:

Telligen Provider Training–
ICF/IID Quality of Care Reviews

June 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

Agenda

- Purpose of Presentation
- Contact Information
- Review Timings Overview
- Required Documentation
- Verifying Eligibility
- Entering Physician Information
- Appeals & Denials
- Website Overview (Telligen & DOM)
- Q&A

AB2

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 related to the submission guidelines.

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

Slide 4

AB1 I would reword this to state something along the lines of, “For specific complaints or to provide feedback on the review process, please send your inquiries to XYZ.”
April S. Burns, 2025-01-13T16:58:43.424

AB2 Shorten to maybe Troubleshoot authorization submission issues.
April S. Burns, 2025-01-14T16:09:08.107

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

- Available Monday – Friday 8 am- 5pm CST
- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Available Monday – Friday 8 am- 5pm CST
- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager

Kim Reed

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Understanding Key Review Terms

Review Timings & Continued Stay Reviews

Review Timings

Review Timing	Definition	When It's Used	Examples	Key Considerations
Prospective	Review conducted **before** services are provided or patient is admitted	When seeking **prior authorization** for scheduled or planned services	▪ Therapy eval request ▪ Scheduled outpatient imaging ▪ Elective surgeries	Must be approved **before** service begins to avoid denial
Concurrent	Review conducted **during** ongoing care	For **ongoing medical necessity** during an active admission or treatment episode	▪ Inpatient hospital stay ▪ Rehab requiring extended length of stay	Submit clinical updates **before current auth ends**
Retrospective	Review conducted **after** the service has been provided	When prior or concurrent review due to eligibility coverage change	▪ Recoupment from MCO or other Insurance notification	Requires **justification** and documentation to avoid denial

Overview of ICF/IID Quality of Care Reviews

Quality of Care Reviews

1.Confirm Continued Eligibility

1. Verify that the individual continues to require an ICF/IID level of care.
2. Assess if the resident is still appropriate for institutional services.

2.Ensure Person-Centered Planning

1. Review the Individual Support Plan (ISP) to ensure it reflects the person's needs, goals, and preferences.
2. Confirm that the care plan is reviewed and updated regularly by the treatment team (at least every 90 days).

3.Monitor Service Delivery

1. Ensure that active treatment and services outlined in the ISP are being delivered.
2. Evaluate documentation (e.g., progress notes) that supports ongoing therapeutic interventions.

4.Support Quality and Safety

1. Identify any concerns about quality of care or over/under-utilization of services.
2. Ensure compliance with federal regulations (e.g., 42 CFR Part 456, Subpart F).

5.Promote Accountability and System Integrity

These reviews are essential for maintaining **clinical standards, regulatory compliance**, and ensuring that **beneficiaries receive the right care in the right setting**.

Quality of Care Due Dates

Reviews are conducted every 6 months Concurrent (initial) and Continued Stay Reviews (CSR). Reviews include utilization and quality checks.

- Concurrent (initial): Due 6 months (180 days) after admission.
- Continued Stay Reviews: Due every 6 months thereafter and must be submitted **before** the current authorization end date.
- Providers may submit reviews up to 60 days prior to the due date, provided all required documentation is available. Telligen sends notifications 30 days in advance to help facilities prepare for submitting Initial and/or Continued Stay Reviews (CSRs) for each beneficiary

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, and 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**.
Align with InterQual or MCG criteria.
Speak the language of the reviewer — match your data to the clinical criteria.
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

Required Documentation

- ❑ DOM-260 ICF-IID Form (new admission)
- ❑ Comprehensive Functional Assessment (full assessment form, not just a summary)
  - ❑ Medical, social, nutritional
- ❑ Metabolic monitoring if on atypical antipsychotics (e.g., labs)
- ❑ Yearly Psych Eval for anyone with an Axis 1 diagnosis. That includes the Adaptive Behavior Assessment. (e.g., Vineland)
- ❑ Person-centered notes and treatment plans (within last six (6) months)
- ❑ Physician orders (within last six (6) months)
- ❑ Medication list (e.g., MAR) (within last six (6) months)
- ❑ Individual Service/Support Plan (ISP) (within last twelve months)
- ❑ Quarterly Review/Comprehensive Team Notes at least every 90 days.
- ❑ Include any hospitalization
- ❑ Include any incident reports

Required Documentation- Care Plan

The care plan should include the following key elements:

1. **Identified Needs/Problems** – Clearly outline the beneficiary's current medical, behavioral, and functional needs.
2. **Goals/Objectives** – Specific, measurable, and person-centered goals that address the identified needs.
3. **Interventions/Services** – Detailed description of the services and supports provided to meet the goals (e.g., therapies, staffing supports, community integration activities).
4. **Responsible Staff/Parties** – Indicate who is responsible for implementing each part of the plan.
5. **Frequency & Duration** – How often and how long each intervention/service will be provided.
6. **Progress Monitoring** – Notes on how progress will be tracked and evaluated.
7. **Date of Plan and Updates** – Include the date the plan was developed and document any updates or revisions.

Electronic 317 Form for ICF-IID

Electronic 317 Form for ICF-IID

Facilities will submit the electronic 317 form to the Regional Office with the required attachments in eLTSS.

Facilities will be required to submit 317s withing 10 business days of an admission AND discharge. Users will be able to track/view the submission/receipt and outcome of the form throughout the process.

Policy:

- A 317 Form is created only after person has been admitted to/discharged from the LTC Facility.
- System Limits for ICF 317 Admissions:
  - Informed Choice Form must be completed in eLTSS (ICFs Only)
  - The person must be admitted into the Facility of the Facility Staffer who is completing the form.

Submit 317 Forms:

- Within **10 business days** of an admission and/or discharge
- Through the **eLTSS system** (not via fax/email).
- For access or questions: email **LTSSPrograms@medicaid.ms.gov**

Training

Training Slides: https://msmedicaid.telligen.com/wp-content/uploads/2025/04/eLTSS-Institutional-Training-Electronic-317-for-ICFS-and-PRTFs-Updated.pdf

Recorded Webinar: https://www.youtube.com/watch?v=zTFVC3O-dyI

Request for Information (RFI)

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 Review

Requesting a Continued Stay Review

Step 1: Access Qualitrac
Log into your Qualitrac provider account.

Step 2: Select Patient Case
Locate and select the **existing** patient case requiring an extension.

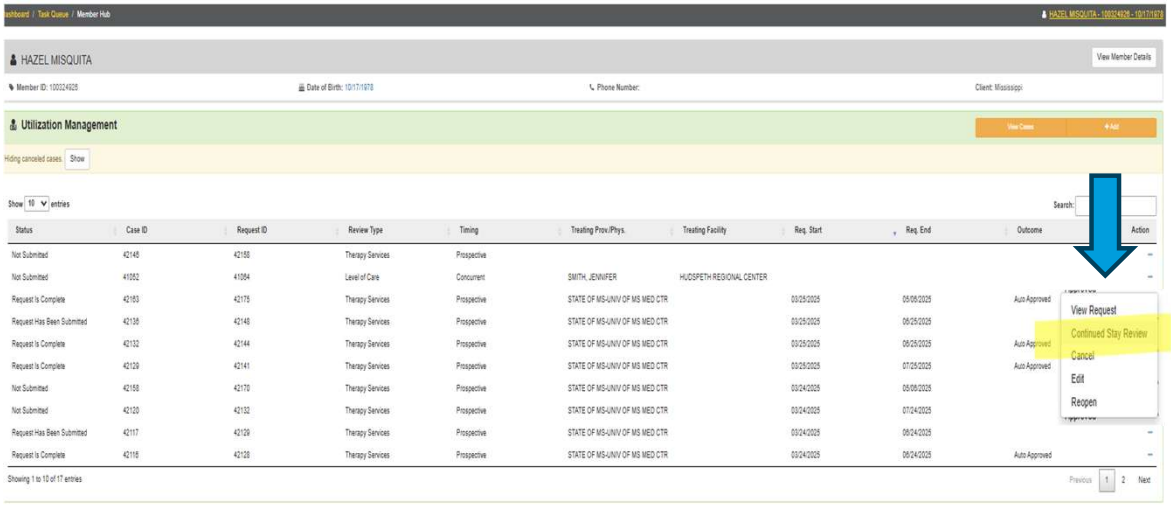
Step 3: Initiate Continued Stay
Click on the "Request Continued Stay Review.

Step 4: Upload Supporting Documentation

Step 5: Update your Assessment (seclusion, restraints and GAF score

Step 6:Complete InterQual process

Step 7: Submit Request



Reminder: Submit extension requests **prior** to expiration of current authori

Submitting a Reconsideration (1st Level Appeal) or P2P Review

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 550 High Street, Suite 1000 Jackson, MS 39201

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

FAQ's, Helpful Links & Survey

FAQs

- **What is the timelines for a new admission to be entered ?**

  For ICF/IID providers, Initial Concurrent Reviews are submitted after the first 6 months from the admission date. After that, Continued Stay Reviews (CSRs) are submitted every 6 months. For example, if a beneficiary was admitted on 12/15/2024, the review period would begin 7/15/2025 to 1/15/2026. You would typically receive notification from Telligen in June(30 days before expiration). Please also ensure DOM 317 Forms are submitted for both admissions and discharges to maintain accurate certification timelines.

- **How do we submit A&I's?**

  The required documents for both Concurrent and Continued Stay Reviews are set by the DOM Administrative Code and support the evaluation of Quality of Care. While A&I details are often found in nursing notes, reviewers may request reports on a case-by-case basis when clinical events or safety concerns arise. If requested, a rationale should be provided. If any request is unclear, feel free to reach out to me for support.

FAQs continued

- **What should I do if the recertification period is different from what's listed in the letter we received?**

  Please refer to the approval letters in Qualitrac for the most accurate certification periods, as they reflect the official review outcomes. If you notice a discrepancy between your records and the list provided, send us a sample case. We'll investigate and address any inconsistencies.

- **What should we do if the number of beneficiaries due is different from what's listed in the letter we received?**

  If there's a discrepancy, please email us a copy of your beneficiary list so we can review and confirm. Our data is based on the client file received from DOM and the cases entered in Qualitrac. Due to transitions between different UM/QIO vendors, some records may be outdated or missing. Sharing your list allows us to reconcile and update our files as needed.

  Reminder: Providers are responsible for submitting all admissions and discharges using the DOM 317 form in the eLTSS system to ensure accurate tracking.

FAQs continued

- Do we complete the InterQual process, if so, how often?

  The InterQual process must be complete with each review.

- Are all reviews submitted considered Retrospective reviews?

  No, the first review for a beneficiary is a concurrent and each review after will be a Continued Stay review.

- How many months of progress notes are to be submitted?

  Each review requires 6 months of progress notes.

- How long from the date of admission to an ICF before we enter information for a continued length of stay?

  A concurrent review is due 6 months after the admission date. Each continued stay review is due every 6 months.

FAQs continued

- What information needs to be submitted for the different reviews?

  You will need to submit the most recent History & Physical, 6 months of progress notes, physician orders, medication lists, goals and progress towards goals, Individual supports plans, and any evaluations/assessments completed during this time.

- How do you complete a discharge?

  Once Telligen completes a review, you will have a discharge task in your queue. You will need to start the task, which will require you to enter a discharge date and upload discharge summary and electronically submit DOM form 317.

- What is required if a person is discharged and readmitted in less than 90 days?

  This requirement has not changed. You will continue to submit the DOM 317 form to the Medicaid Regional Office. It is not required that you notify Telligen.



Reset

EXCHANGE OF INFORMATION BETWEEN
LONG TERM CARE FACILITY AND
REGIONAL MEDICAID OFFICE

MISSISSIPPI DIVISION OF MEDICAID

Name of Facility _____

Provider # _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Medicaid applicant or recipient information:

Name _____

Medicaid ID # _____ Social Security # _____

County of Residence before entering facility _____

Does individual receive SSI? ☐ Yes ☐ No If yes, amount $ _____

Name of Responsible Person _____ Phone # _____

Address of Responsible Person _____

Facility Reported Information:

☐ Individual entered facility (Mo/Day/Yr) _____ Medicaid application provided? ☐ Yes ☐ No

Entered facility from: ☐ Home ☐ Hospital ☐ Other Facility: Give name of hospital or other facility & dates of admission: _____

☐ Individual is deceased. Date of death (Mo/Day/Yr): _____ ☐ Died in this facility ☐ Place of death _____

☐ Individual was discharged to another facility on (date) _____

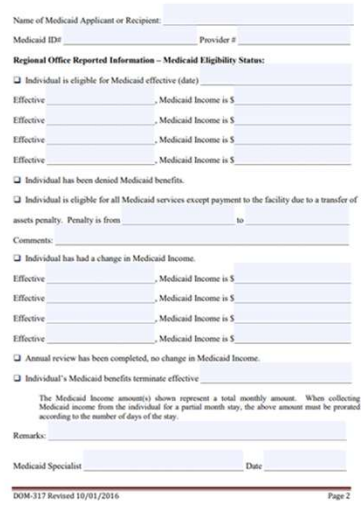
Name/address of new facility: _____

☐ Individual has been discharged to a private living arrangement on (date) _____

Address _____ Phone # _____

Signature of Facility Official _____ Date _____

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Name of Medicaid Applicant or Recipient: _____

Medicaid ID# _____ Provider # _____

Regional Office Reported Information – Medicaid Eligibility Status:

☐ Individual is eligible for Medicaid effective (date) _____

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

☐ Individual has been denied Medicaid benefits.

☐ Individual is eligible for all Medicaid services except payment to the facility due to a transfer of assets penalty. Penalty is from _____ to _____

Comments: _____

☐ Individual has had a change in Medicaid Income.

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

Effective _____, Medicaid Income is $ _____

☐ Annual review has been completed, no change in Medicaid Income.

☐ Individual's Medicaid benefits terminate effective _____

The Medicaid Income amount(s) shown represent a total monthly amount. When collecting Medicaid income from the individual for a partial month stay, the above amount must be prorated according to the number of days of the stay.

Remarks: _____

Medicaid Specialist _____ Date _____

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Helpful Links

- **Education/Training**

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

- **Document Library**

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

- **DOM Form 260** **(new admission)**

DOM-260-ICF-IID-Pre-Admission-Form.pdf

- **DOM Form 317**

(Submit electronically admit/discharge)

DOM-317-Form.pdf

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
Kim Reed

Assistant Program Manager
Cassandra Bullock

Survey

Thank you for attending the training! Your feedback will help us improve our sessions and address any additional needs you may have. Please take a few minutes to complete this survey.

https://forms.office.com/r/YRh7kSZ7Qv

