Mississippi Medicaid:

Telligen Provider Review Training – Therapy Services

July 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

- Agenda
- Contact Information
- Review Timing Overview
- Verifying Eligibility
- Entering Physician Information
- InterQual
- RFI, Change Request and Discharge Task
- Appeals & Denials
- Website Tour
- Q&A

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

Review Timing Overview

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

Verifying Eligibility
Physician / Facility Information

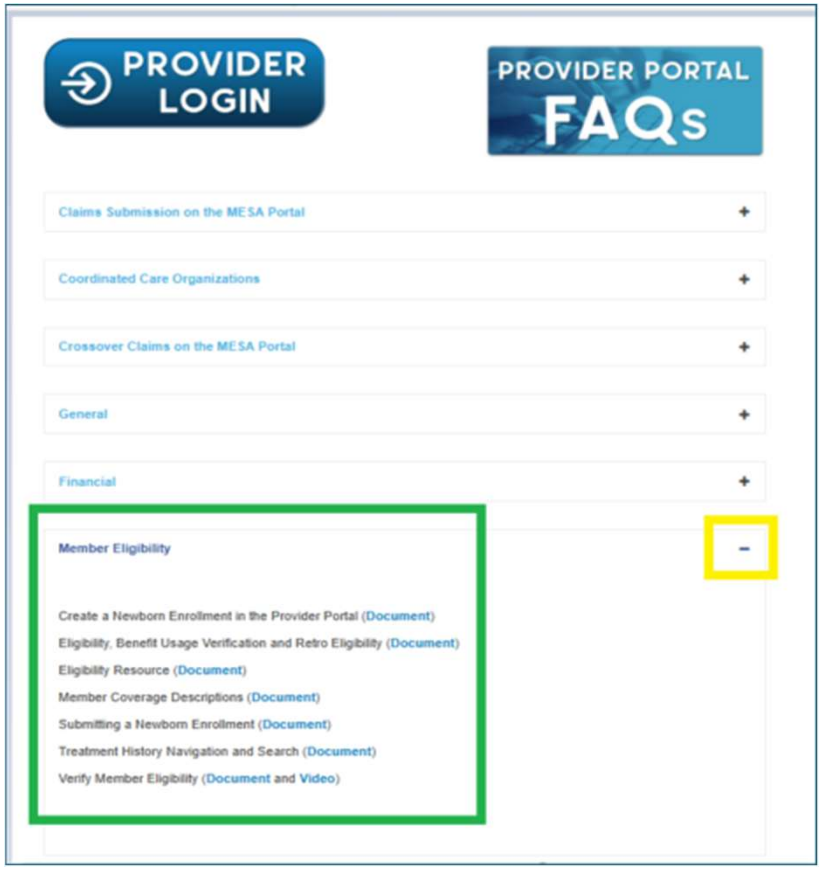
Verifying Eligibility

Why Eligibility Verification Matters

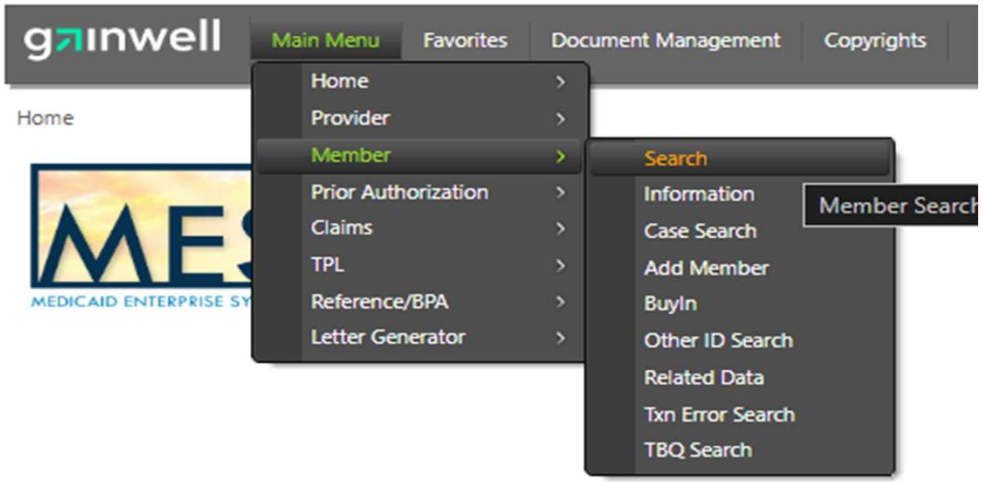
- Confirms active Medicaid coverage for the date of service
- Avoids denials due to eligibility issues
- Provides details on benefit plans, managed care assignments, and limitations

Key Reminders

- **Always** verify eligibility **before submitting Prior Authorization Request**
- **Always** verify eligibility **before providing services**

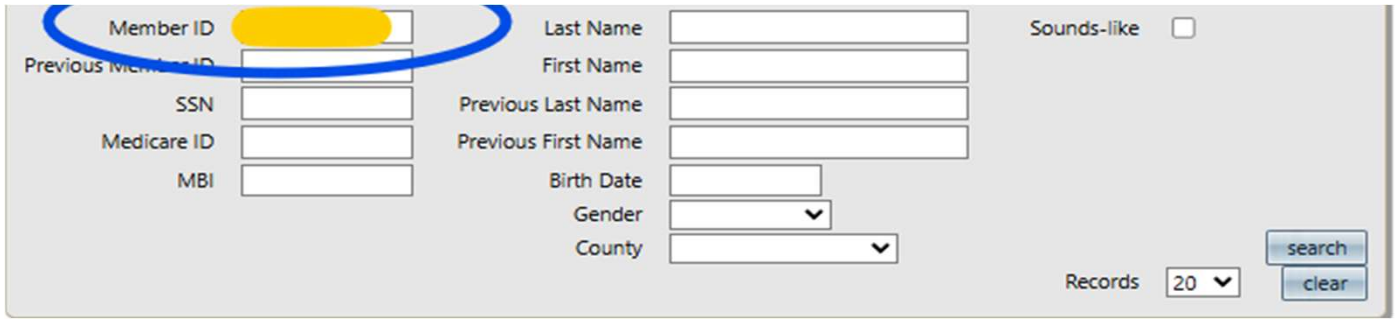


Verifying Eligibility



Accessing Eligibility in MESA Portal

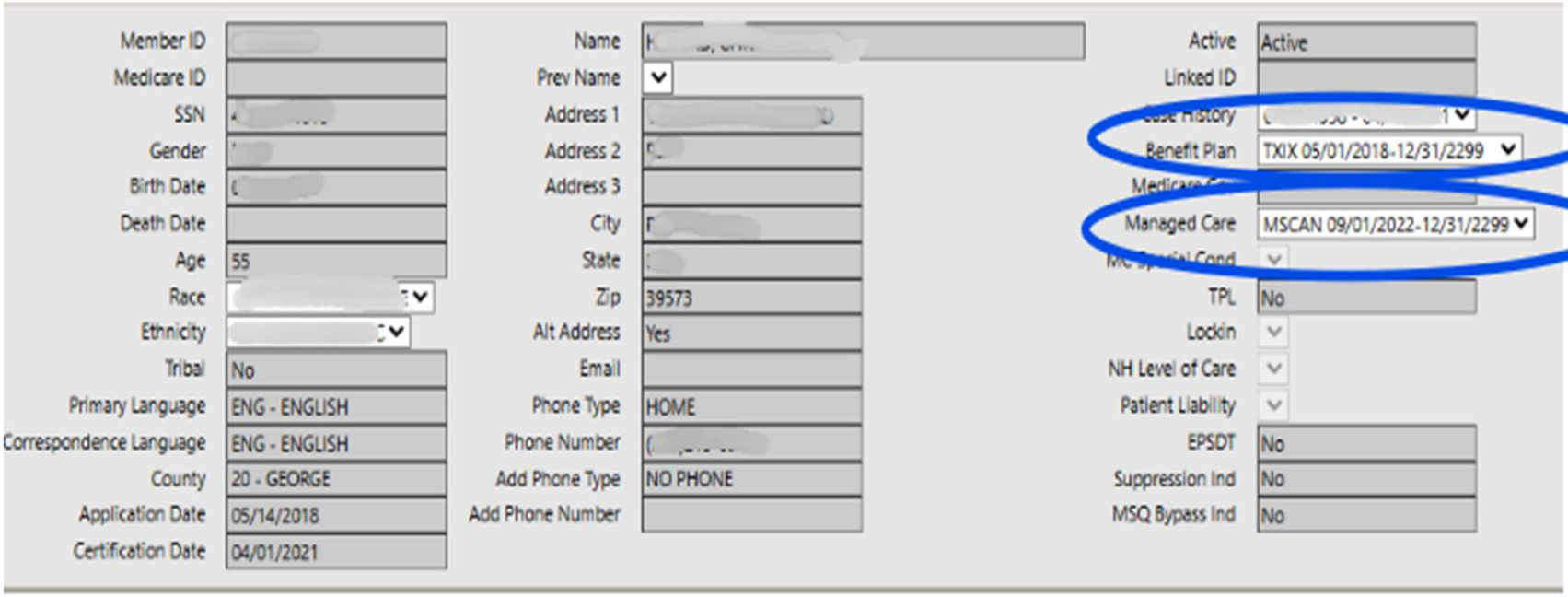
4. Enter one of the following:
   - Member ID
   - Or two of: SSN, birth date, full name



Verifying Eligibility

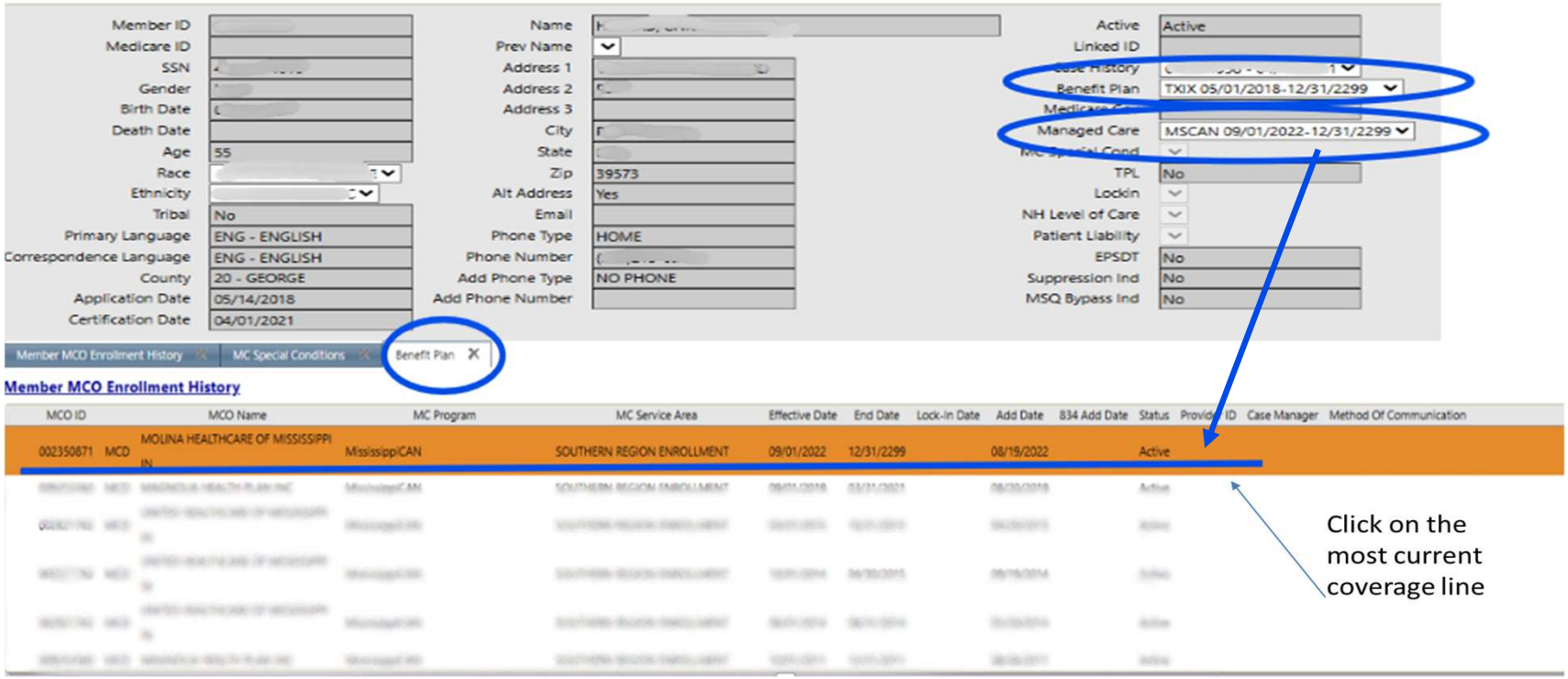
Beneficiary Record Summary

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



Regardless of coverage, Telligen will review cases for: **Swingbed services, ICF-IID & KBP (formerly DCLH)**

Verifying Eligibility Beneficiary Plan Add Date

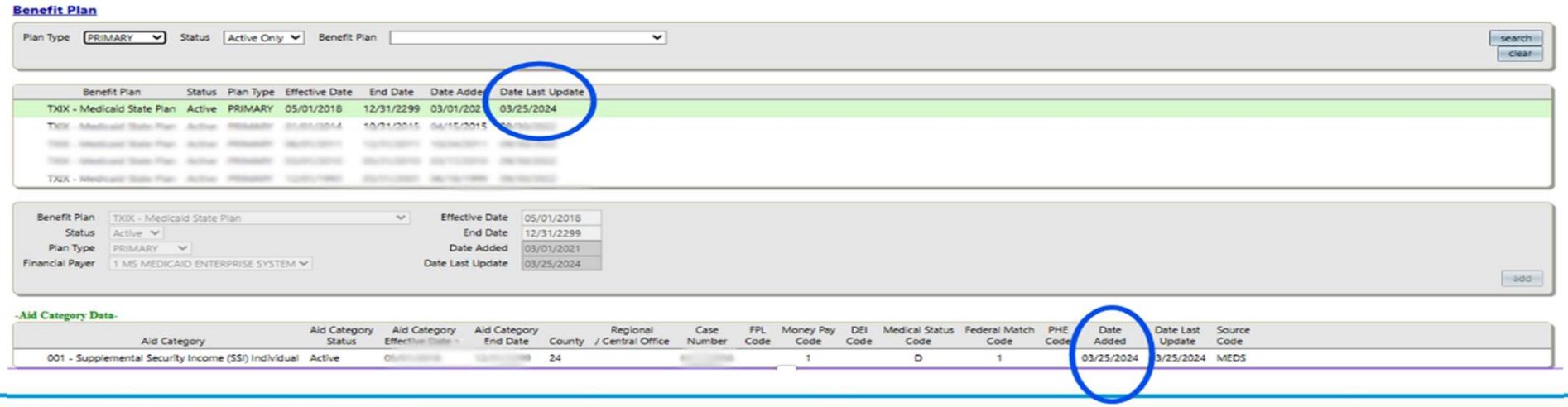


Verifying Eligibility **Admin Guidelines for Retro Eligibility**

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:

If the Date of Service occurs **before the Add Date**, the patient is considered **retro eligible**.



Verifying Eligibility Example of Retro Eligible

Date of Service (DOS): 2/4/2025
Benefit Add Date in MESA: 4/2/2025
📌 **Explanation:**
The Date of Service **(2/4/25)** occurred **before** the Add Date **(4/2/25)**.
Because the DOS is earlier than the Add Date, the patient is **retro eligible**.

Providers have **90 calendar days from the Add Date (4/2/25)** to submit a prior authorization request.

Verifying Eligibility Not Retro Eligible

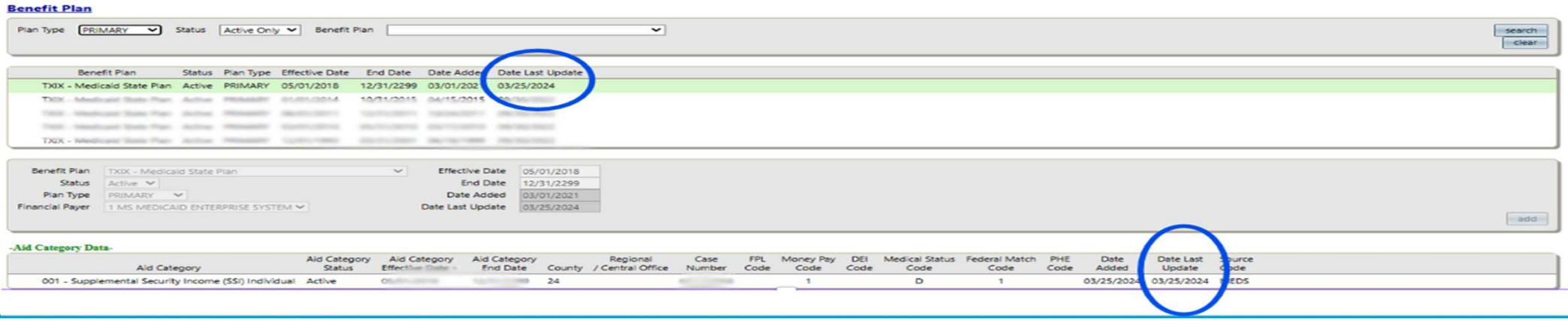
Date of Service (DOS): 6/2/2025

Benefit Add Date in MESA: 3/25/2024

📌 **Explanation:**

The Date of Service **(6/2/25)** is **after** the Add Date **(3/25/24)**.

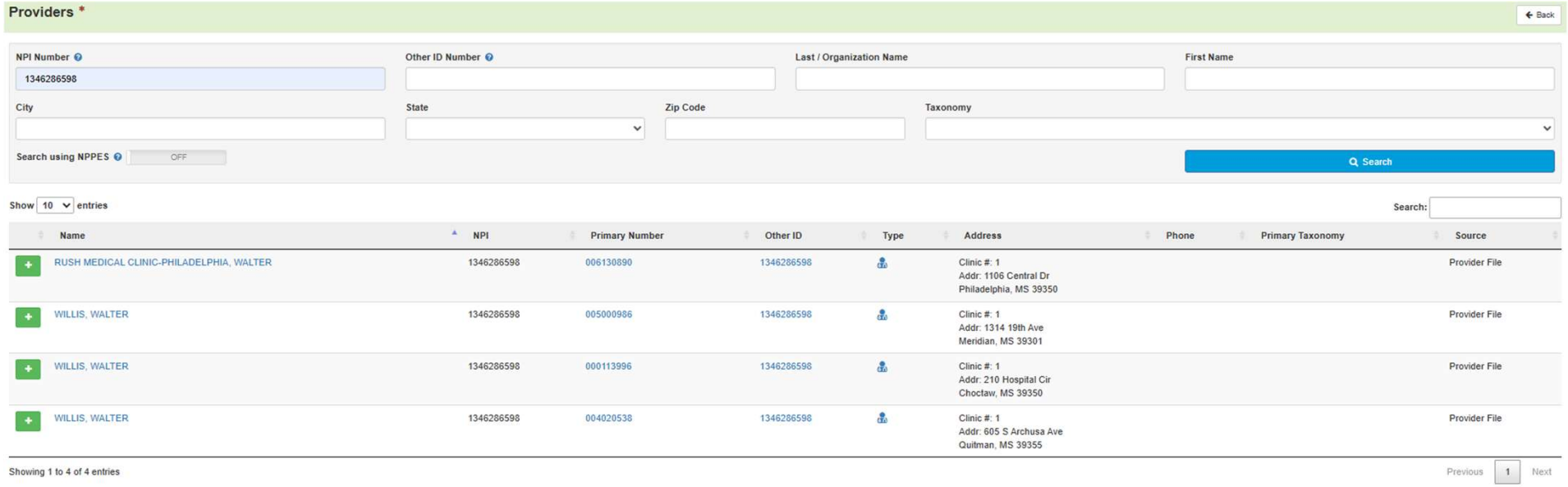
Because the DOS occurs **after** the Add Date, the patient is **not retro eligible**.



Entering Physician / Facility Information

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.

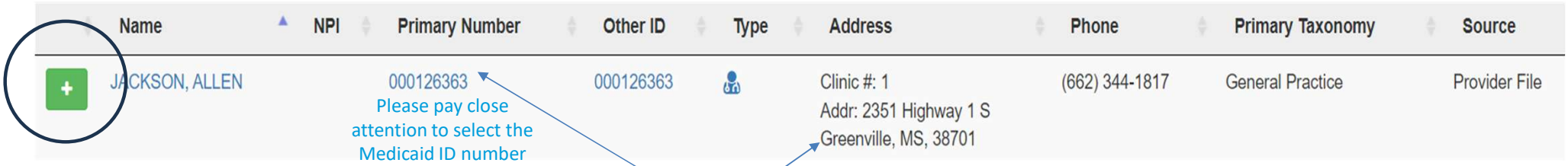


Entering Physician and Facility Information

- 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

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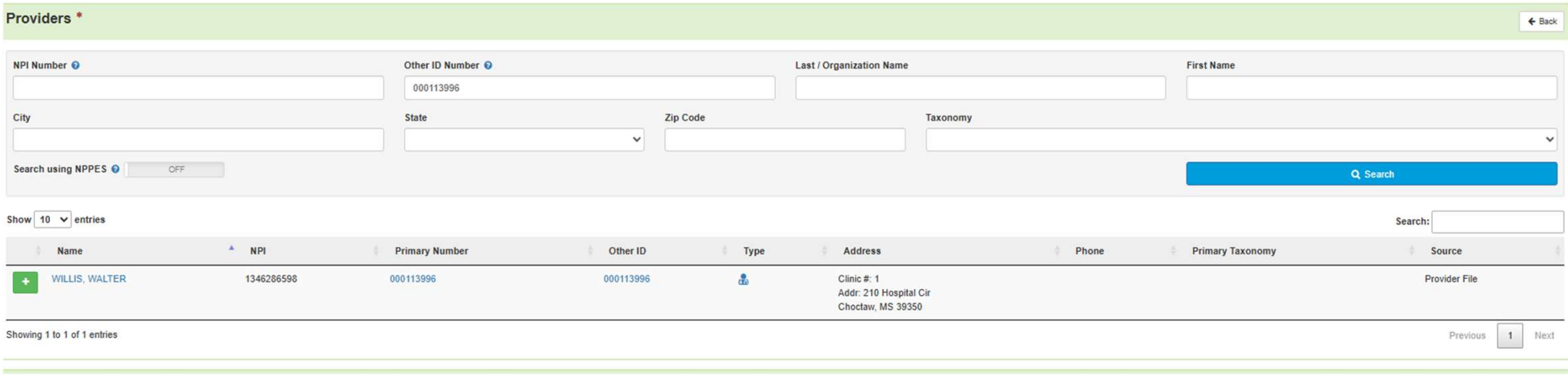


Submitting a Review

Telligen Provider Portal – Required sections

The following panels will be required for your request:

Authorization Request Type (Review Type, Place of Service, Type of Service and Timing)

Dates of Service (start and end date)

Eligibility Verification

Providers

Diagnosis &Procedures

Documentation

InterQual

Procedure Units & Modifiers

Procedure Units

Providers are responsible for calculating the units based on the duration of services.

The PA is for the total units for duration of the requested dates of service.

For example, the beneficiary order for 97110 3 x a weeks for 6 weeks.

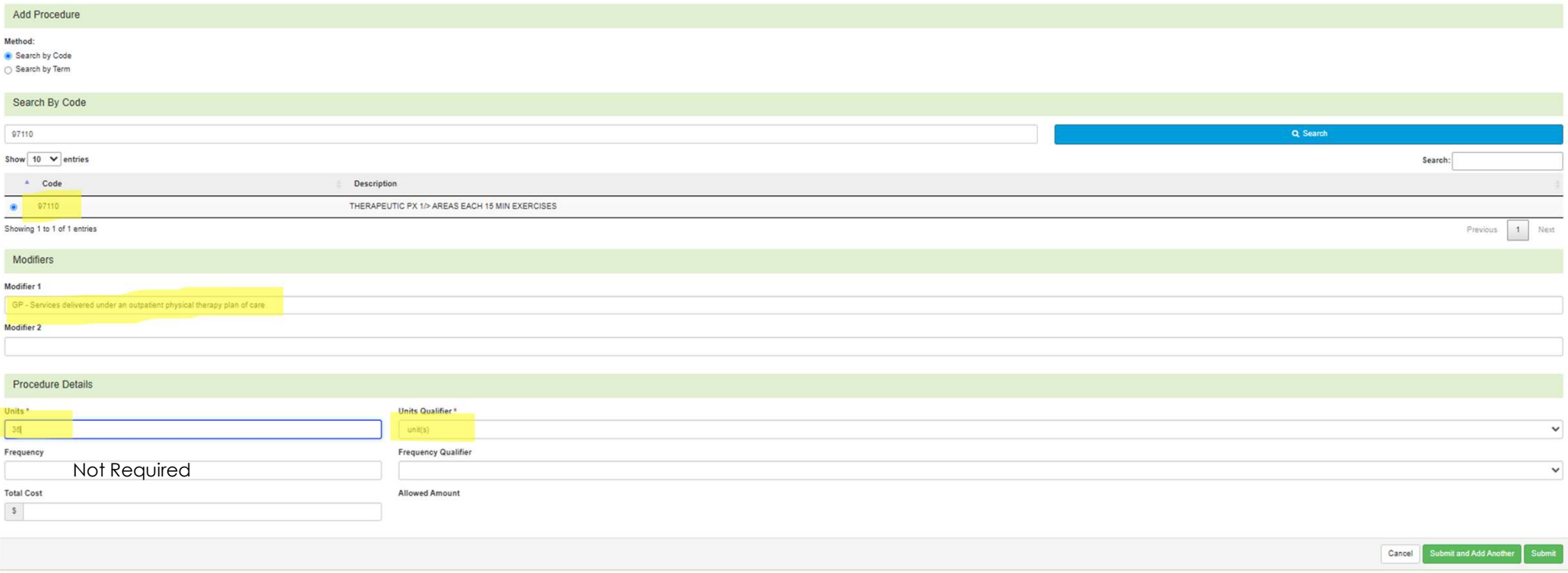
Calculate Sessions:3 sessions/week * 6 weeks = 18 sessions.

- If each session is 30 minutes:
- 18 sessions * 30 minutes/session = 540 total minutes.
- 540 minutes / 15 minutes/unit = 36 units

- Final units requested for 97110 is 36 units

This formula would be used for each code requested per procedure

Procedure Units



Documentation

Required Documentation

Required Documentation:

- **Plan of Care** (required: specific certification periods and total units for the requested DOS)
- **Certificate of Medical Necessity** (must include the date of the last visit, within 6 months of Date of Service (DOS)
- **Documentation of face-to-face encounter** (Physician MD must sign the referral)
- **Initial or Re-evaluation Document** (must be signed by a Therapist)
- **Three (3) Most Recent Progress Notes** (including treatment modalities and daily progress toward goals)
- **Discharge Summary** (required if beneficiary is transitioning to a new company)
- **Individualized Education Program (IEP)** (if applicable)

InterQual

Navigating InterQual

InterQual® is a clinical decision support tool used to ensure that healthcare services are **medically necessary**, **evidence-based**, and **appropriate** for the level of care being requested.

InterQual is integrated into Qualitrac, it guides providers through standardized decisions, reduces claim denials, and identifies appropriate Medicaid patient care levels.

Submit Clear Clinicals

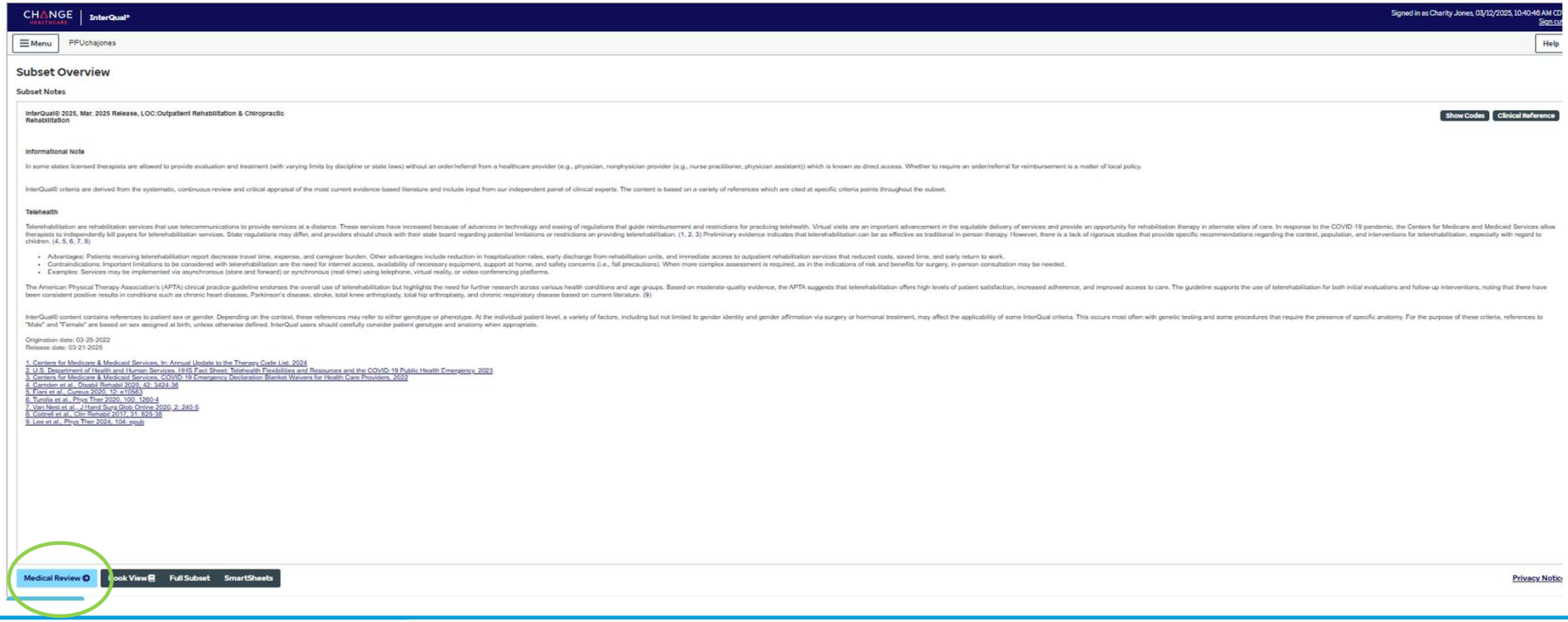
- Ensure documentation includes:
  - Diagnosis
  - Onset of condition
  - Current treatment plan
  - Response to treatment
  - Vital signs, labs, imaging results (as applicable)

Match Criteria to Documentation

- Review the **InterQual guidelines** for that service type through Qualitrac
- Make sure **each InterQual criterion is supported by clinical evidence** in your submission.

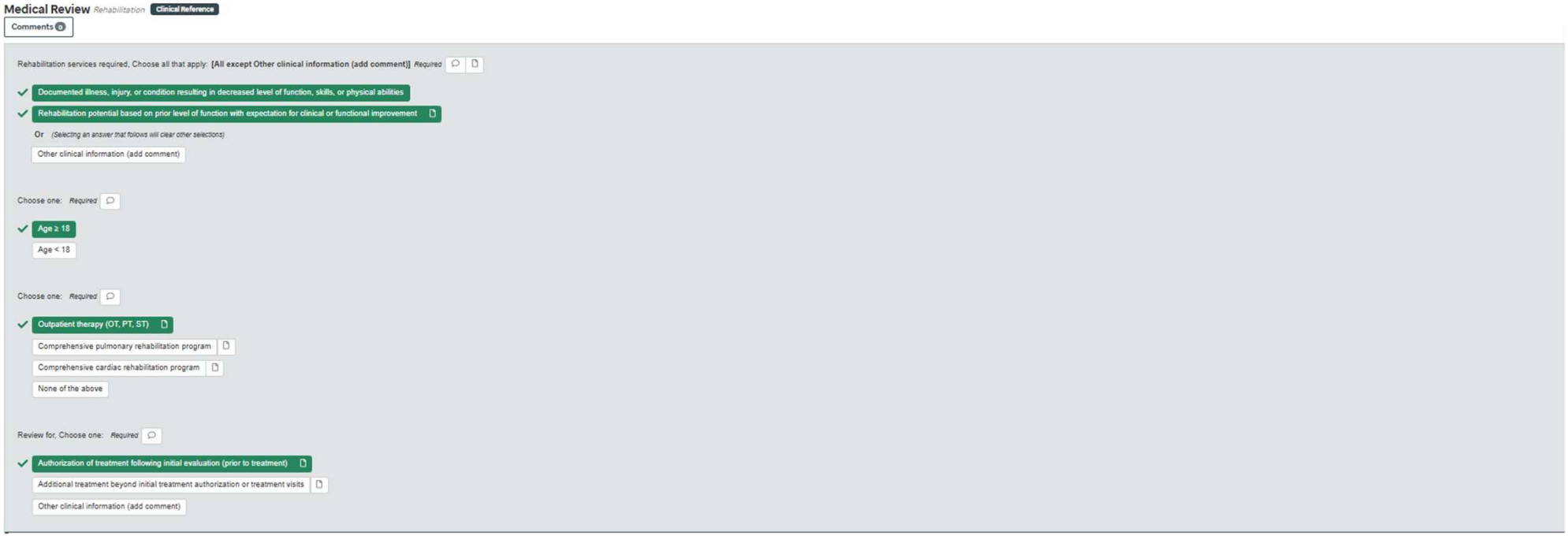
InterQual Process cont.

click Medical Review to begin



InterQual Process Example cont.

- Make sure you choose ALL that apply:



InterQual Process Example cont.

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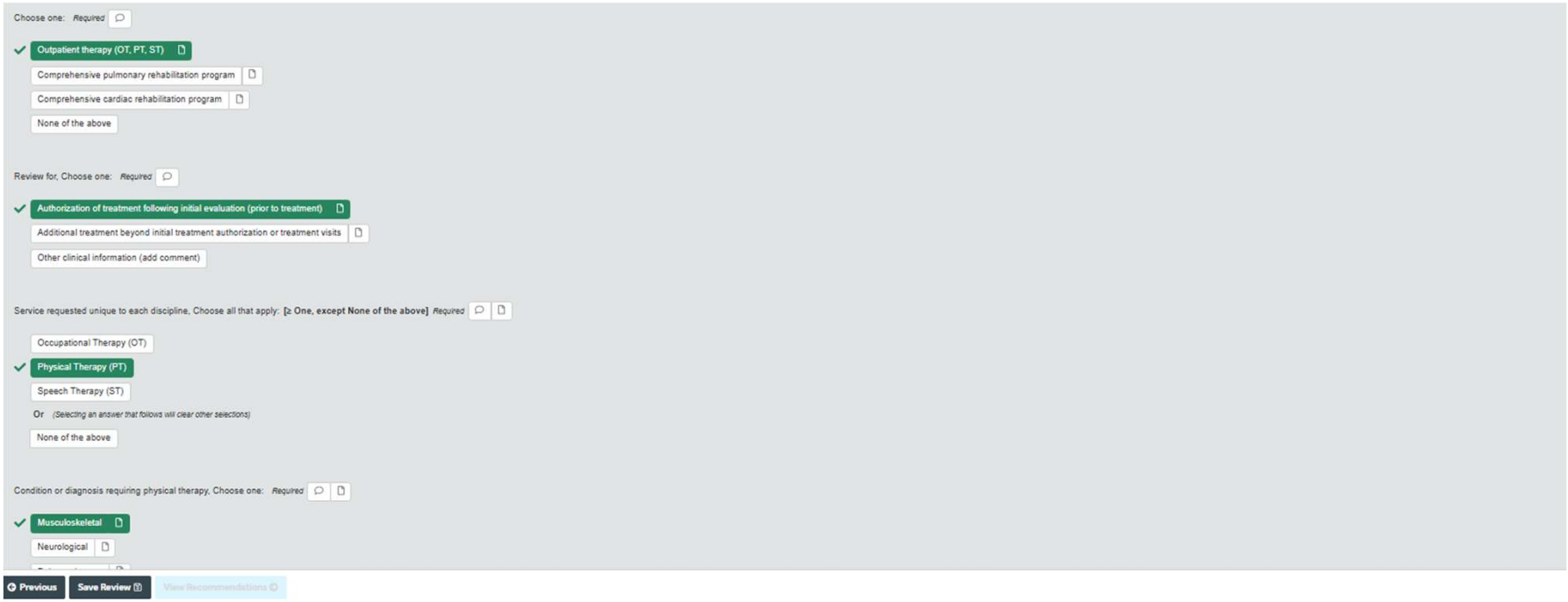

InterQual Process Example cont.

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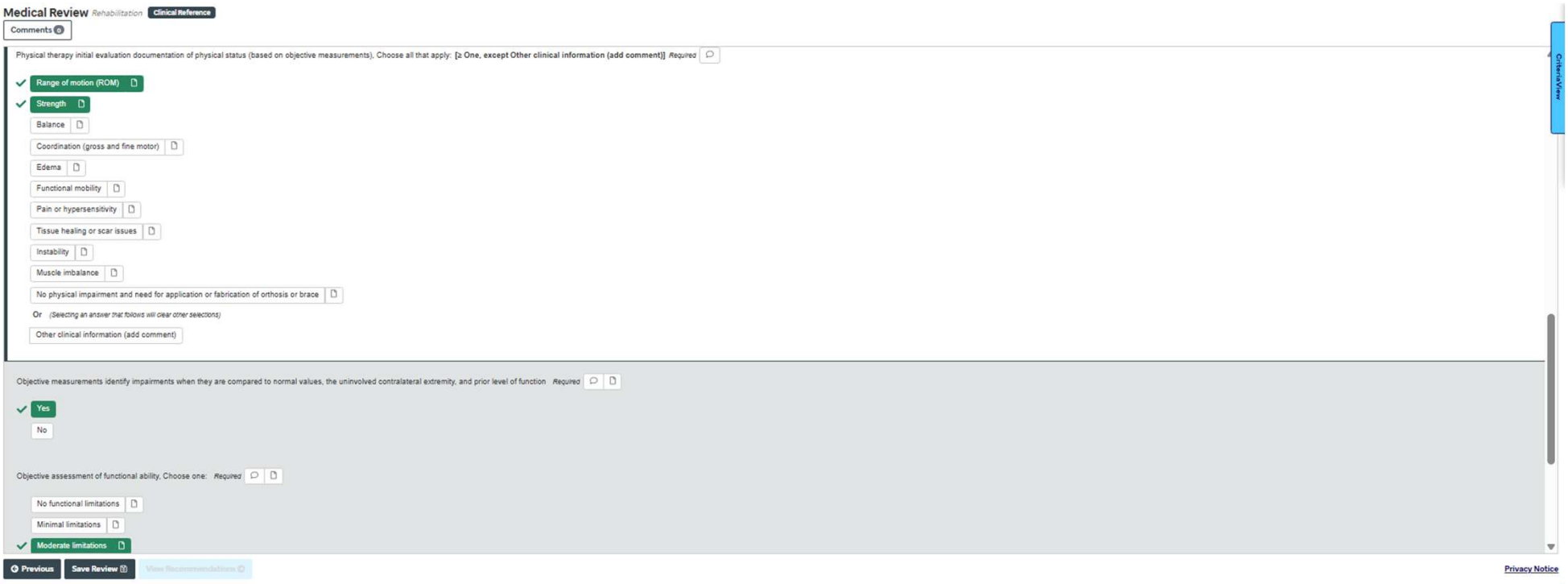
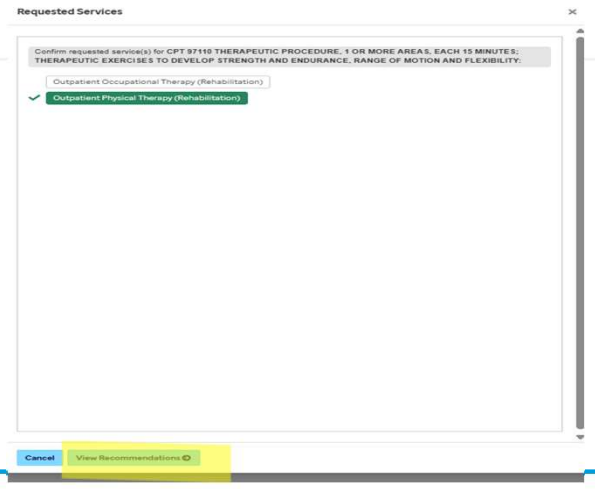


InterQual Process Example cont.

- click View Recommendations



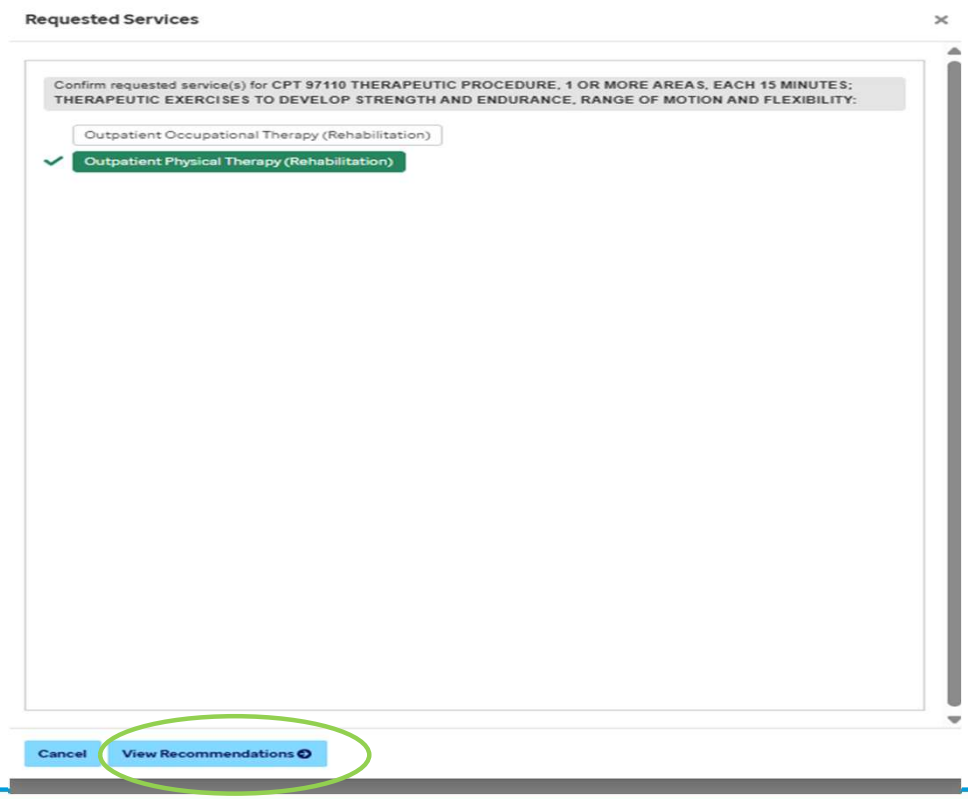
A confirmation box will open to confirm requested services



click View Recommendations

InterQual Process Example cont.

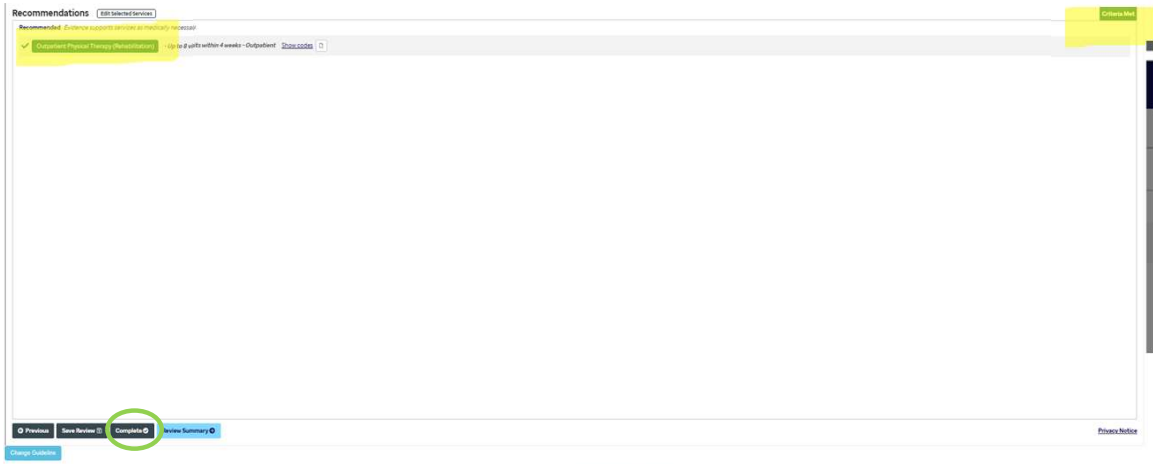
A confirmation box will open to confirm which requested services



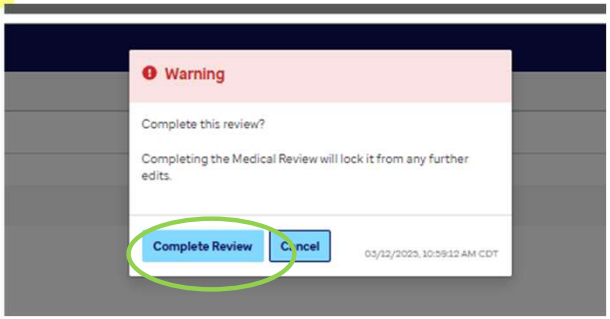
click View Recommendations

InterQual Process Example cont.

A confirmation box will open to confirm which confirms the Criteria Met and recommendations.

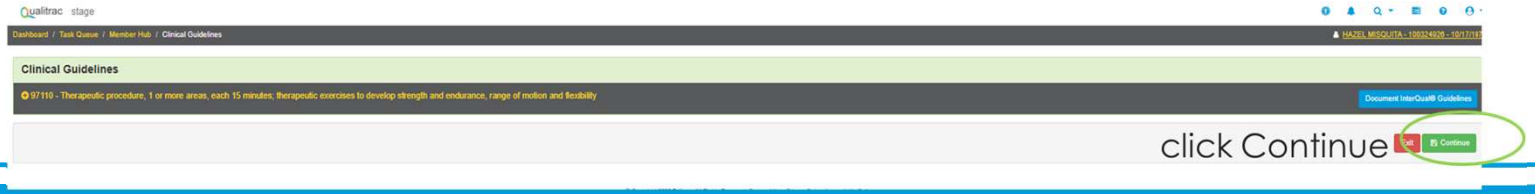


A confirmation box will open



click Complete Review

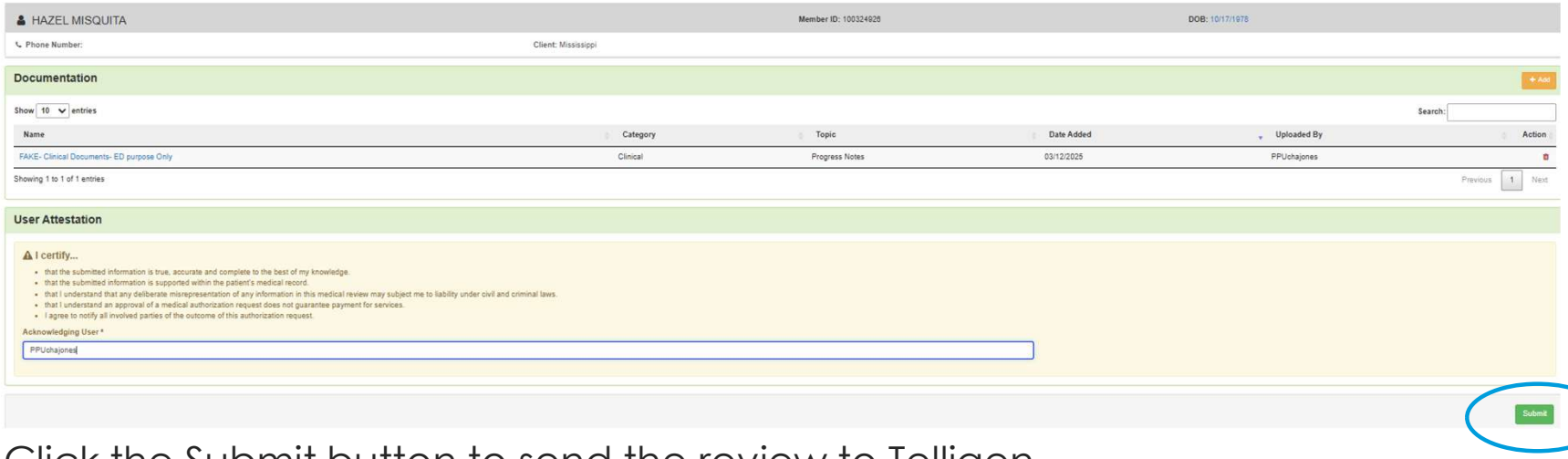
Click continue to integrate InterQual recommendation into Qualitrac



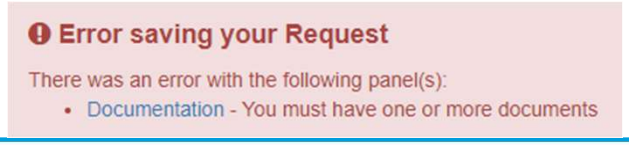
click Continue

Attestation

- The last piece of submission is to enter your **Username** in the attestation section

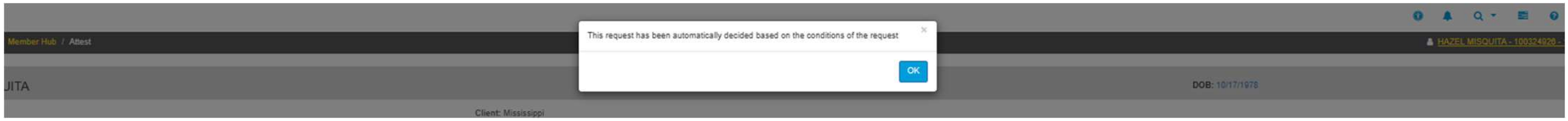


- Click the Submit button to send the review to Telligen
- If any information is missing, an error will indicate what is missing



InterQual Process Example cont.

If the InterQual Process is completed correctly, you should instantly receive an Auto-Approved Notification box and email



Outcomes — Review Outcome: Auto Approved

(HCPCS) 97110 - THERAPEUTIC PX 1/> AREAS EACH 15 MIN EXERCISES

Requested		Final Recommendation	
Outcome		Outcome	Auto Approved
Authorization Number		MCG Guidelines	No Guidelines
Start Date	03/25/2025	Authorization Number	Q0000000700
End Date	05/06/2025	Start Date	03/25/2025
Modifier 1	GP	End Date	05/06/2025
Modifier 2		Modifier 1	GP
Modifier 3		Modifier 2	
Modifier 4		Modifier 3	
Units	36 unit(s)	Modifier 4	
Frequency		Approved	36 unit(s)
Total Cost	$0.00	Frequency	
		Total Cost	
		Manual Pricing: No	
		Letter Rationale:	

InterQual Process :No Guidelines/Recommendation

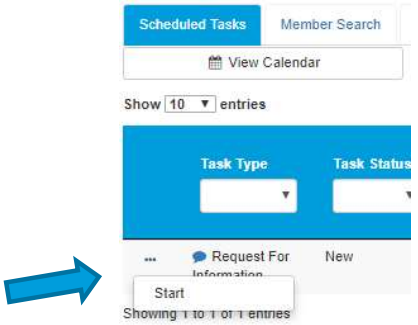
- If there are no clinical guidelines that apply, you will be presented with a text box where clinical information relevant to the review can be entered.
- Once all applicable data has been entered, click the **submit** button to finish the documentation.



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.

Submitting Change Request

Change Request Guidelines

A **Change Request Form** is used to request **simple modifications** to an already approved prior authorization (PA), such as:

- Updating provider information
- Modifying a billing code modifier
- Correcting service dates

Submission Instructions:

Submit your Change Request **within 90 days** of the PA approval date listed in your decision letter.

- Fax to **800-524-5710** or email to **MSMedicaidUM@Telligen.com**

(Be sure to include all relevant documentation to support your request.)

You must submit a **new PA request** if you need to:

- **Add or replace HCPC codes** *(Include a note requesting cancellation of the original case.)*
- **Make changes to already paid claims** *(The claim must be voided and the original PA canceled before submitting a new request.)*

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

Requesting an Extension of Services

Extension of Services

- Providers may request to extend a beneficiary's stay beyond the initially approved authorization period. All extension requests **must be submitted prior** to the current authorization end date.

- **Extension of Service:**
  - Ensures **continuity of care and quality of care**
  - Provides **medical justification** based on **clinical criteria**
  - Must be submitted **before** the current auth end date
  - Maintains compliance with **Mississippi Medicaid** regulations and avoid **claim denials** due to lack of prior approval

Requesting a Continued Stay Review

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

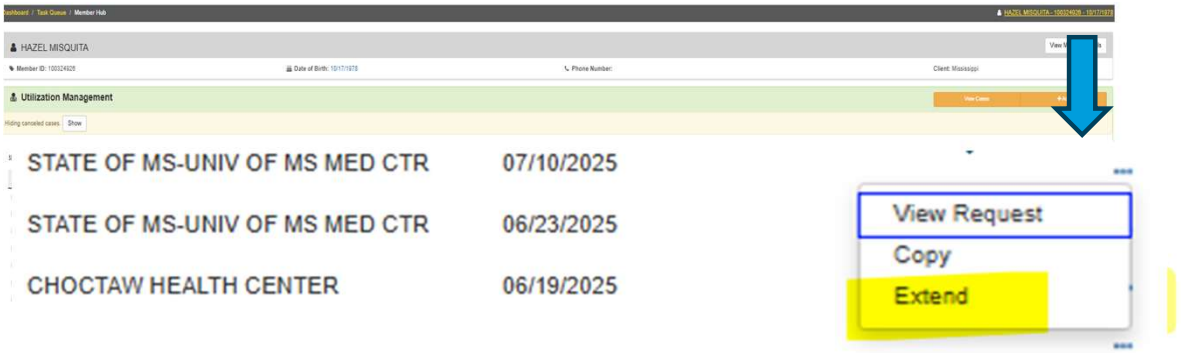
Step 2: Select Patient Case
Locate and select the **existing** patient case requiring an extension.

Step 3: Initiate Request Extension
Click on the "Request an Extension.

Step 4: Upload Supporting Documentation

Step 5: Complete InterQual process

Step 6: Submit Request



Reminder:
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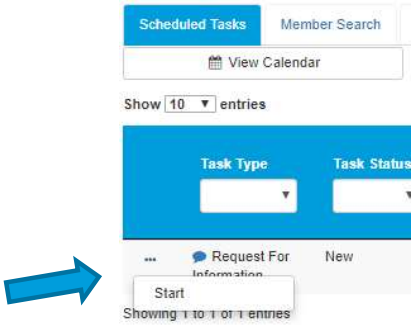

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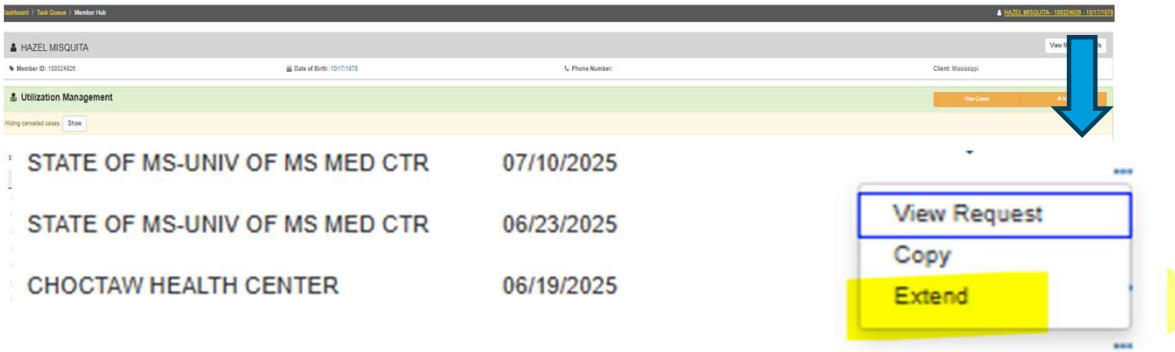
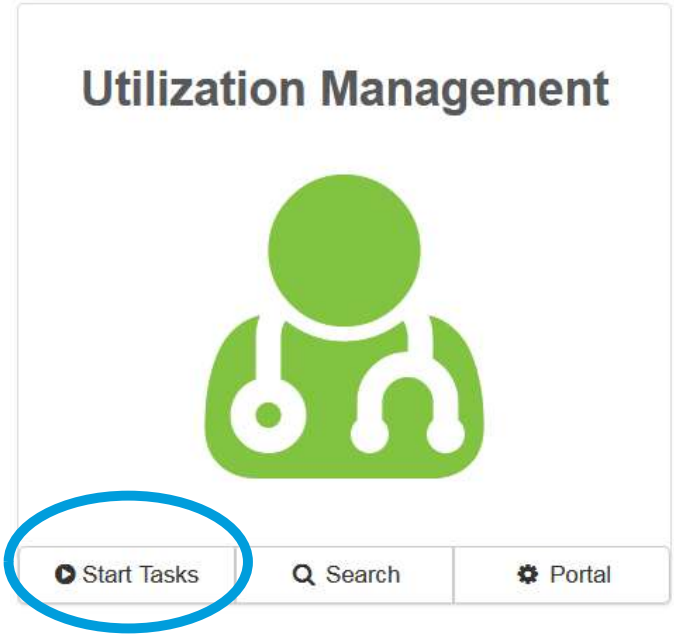


Reminder:
Submit extension requests **prior** to expiration of current authorization.

Discharge Task

Discharge Information Task

- Providers will receive a Discharge Information Task.
- This task will be shown in the scheduled task queue with the task type of "Discharge Status."
    - If the member has not been discharged and is still in the facility, the task does not need to be started until the discharge occurs.
- If an extension of stay (CSR) is submitted, the task will be removed and a new task will be displayed once the Continue Stay Review has been completed.



Discharge Information

- **Discharge Documentation** The completed Discharge disposition that includes the date of discharge

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

- **Completing the Task**: Once all the information has been entered in the panels, the user can complete the process by clicking the "Close Case" button at the bottom of the page.

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 via Provider Help Desk
- **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

Website Tour
Q&A

Contact Us

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

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.