Mississippi Medicaid:

Telligen Provider Portal Training – Inpatient Hospital Services

July 2024

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Agenda

- Contact Information
- Overview/Purpose
- Housekeeping
- Mississippi Prior Authorization Reform Act (S.B. 2140)
- Telligen/Mississippi Medicaid Website
- Completing the Request for Information (RFI)
- How to find a determination
- Submitting a reconsideration/appeal/Peer to Peer Review
- Continued Stay Review (CSR)
- Discharge Tasks
- E-mail notifications
- Questions

Contact Us

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- Email: *msmedicaidum@telligen.com*
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- Fax: 800-524-5710

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

Purpose

- Instructions on completing the Request for Information process
- How to find a determination status after submitting a review
- Instructions on submitting a reconsideration/1st level appeal
- Directions on requesting a Peer-to-Peer review
- Directions on requesting a Continued Stay Review
- Directions on submitting a Discharge
- Review of the notifications you will receive

Housekeeping

- **Questions**
  - Please enter all questions into the Q&A
  - Time at the end of the training will be reserved for questions
  - Any unanswered questions will be answered and posted to the website

- **Content availability**
  - Presentation will be posted to the website following the training
  - **Website**: https://msmedicaid.telligen.com/
  - Located in Education/Training

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

MS Prior Authorization Reform Act

Senate Bill 2140

- The Mississippi Prior Authorization Reform Act, effective July 1, 2024, aims to address issues related to prior authorization requirements and improve healthcare delivery and outcomes in MS.
- Overall, the Mississippi Prior Authorization Reform Act is intended to balance controlling healthcare costs and ensuring timely access to necessary medical treatments for patients.

MS Prior Authorization Reform Act, cont.

Senate Bill 2140

- Key provisions of the MS Prior Authorization Reform Act:
  - Streamlining Processes
  - Transparency
  - Clinical Justification
  - Appeals Process

MS Prior Authorization Reform Act, cont.

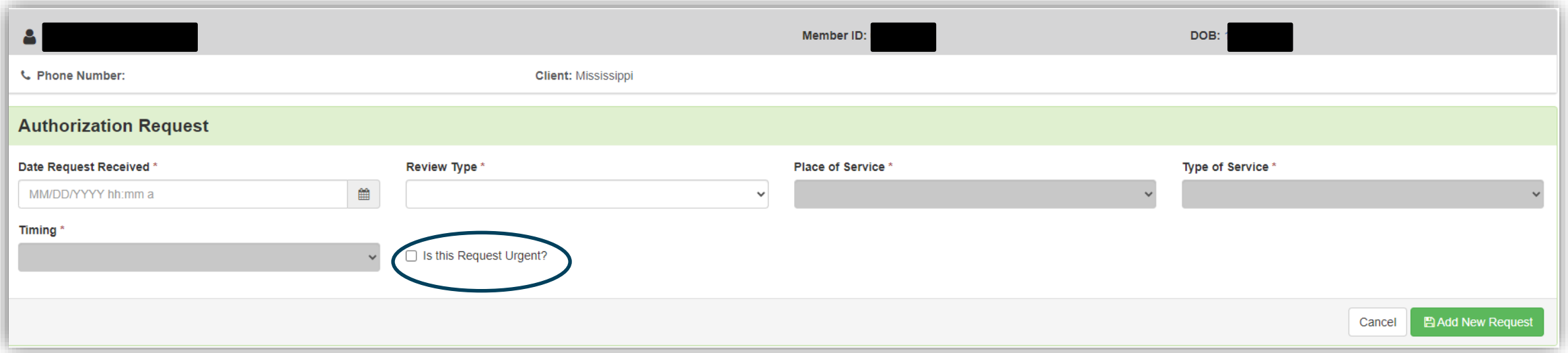
How will this impact the current prior authorization process?

Prior authorization is a process where healthcare providers are required to obtain approval before certain treatments, procedures, or medications can be covered.

You will submit **non-urgent prior authorization requests** as you have previously and adhere to the turnaround times as before.

- The urgent feature in Qualitrac allows the provider to indicate when a prior authorization request needs to have expedited processing due to its urgent nature.
- Selecting the "urgent" checkbox triggers an escalation process within the system, directing the request to be reviewed more quickly and given a higher priority.
- **Do not utilize this feature for non-urgent prior authorization requests.**

Urgent Feature in Qualitrac



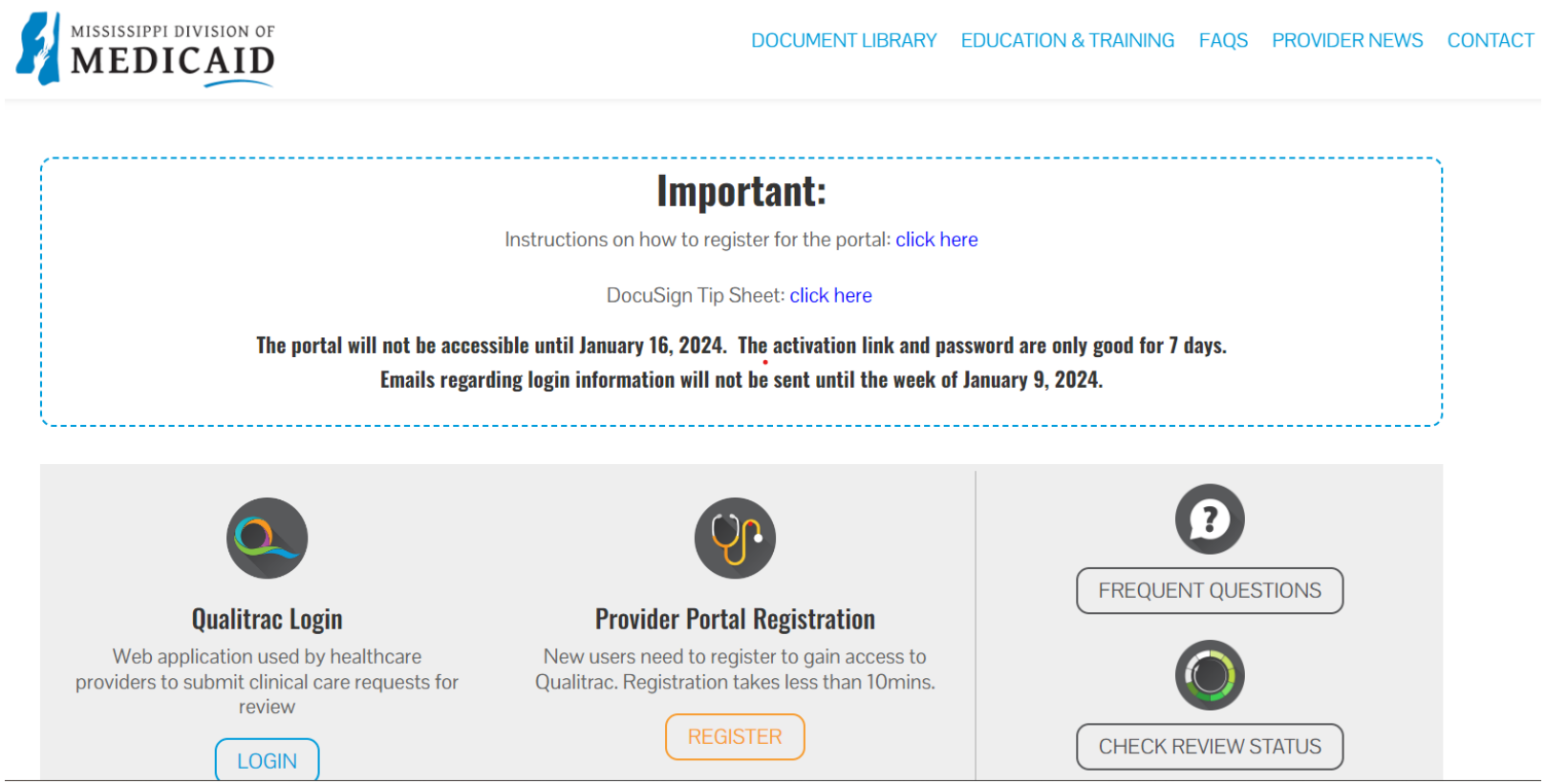
MS Prior Authorization Reform Act, cont.

Urgent Health Care Services-S.B. No. 2140 p.7

- (p) "Urgent health care service" means a health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a treating health care professional or health care provider with knowledge of the enrollee's medical condition:
  - (i) Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function;
  - (ii) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; or
  - (iii) Could lead to likely onset of an emergency medical condition if the service is not rendered during the time period to render a prior authorization determination for an urgent medical service.
- (q) "Urgent health care service" does not include emergency services.
- A determination must be rendered no later than 48 hours after receiving **all** information needed to complete the review of the requested *urgent health care service* (Sect.8)

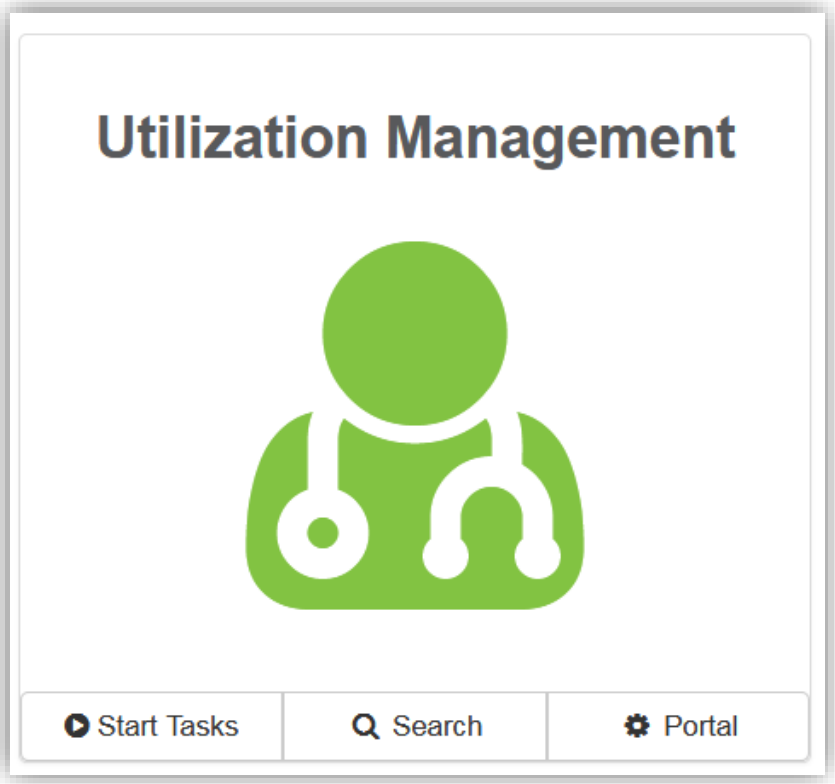
Telligen Landing Page Overview

Please bookmark this site: https://msmedicaid.telligen.com



Telligen Provider Portal – Landing Page

- **Start Tasks** will take you to the task queue to view any reviews where additional information has been requested
- **Search** will allow you to search for a member or a case. Just like the magnifying class at the top of the page.
- **Portal** will take you to the portal or to the task queue.



Submitting a Review

Inpatient Acute Prior Authorization

A prior authorization is required for all hospital admissions except:

- obstetrical deliveries
  - vaginal deliveries with a length of stay of two (2) days or less
  - cesarean deliveries with a length of stay of under four (4) days or less
- well newborns with a length of stay five (5) days or less.

- Emergent and urgent admissions must be authorized on the next working day after admission.
- Lack of authorization = denial, if the exceptions aren't met.
- Inpatient hospital stays that exceed the DRG Long Stay Threshold (19 days) require a continued stay/concurrent review for the additional inpatient days that exceed the threshold.

Maternal-Infant Inpatient Prior Authorization

Report all admissions for deliveries to DOM and Telligen via the Newborn Enrollment form.

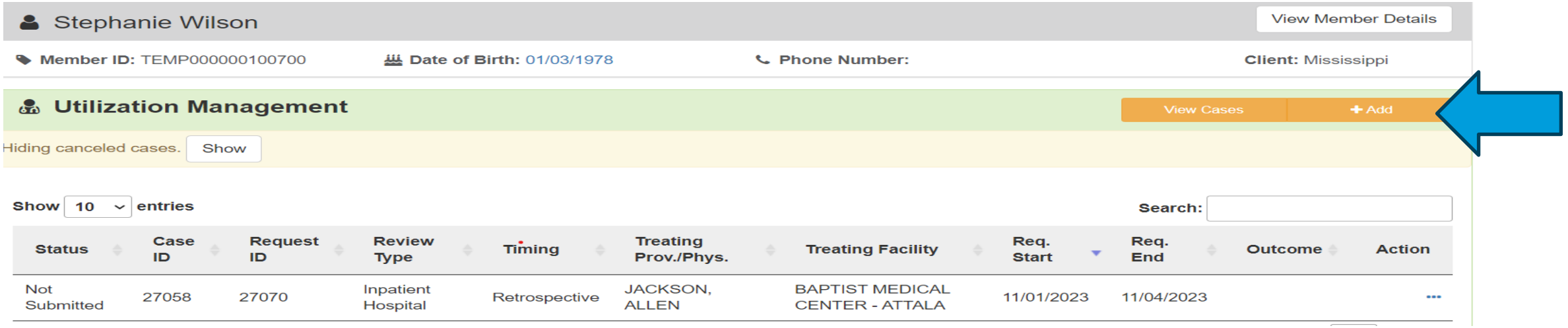
- A prior authorization is required for maternal–infant admissions when:
  - obstetrical deliveries
    - vaginal deliveries with a length of stay of three (3) or more days
    - cesarean deliveries with a length of stay of five (5) or more days
  - sick newborns with a length of stay six (6) or more days

- Obstetrical deliveries and sick newborn stays that exceed nineteen (19) days require a continued stay/concurrent review.

Telligen Provider Portal – Utilization Management Panel

The **Utilization Management Panel** will contain all information related to all UM reviews submitted for the member on behalf of your organization or those that were shared with your organization through the provider visibility panel

Use the + Add button to start a new request.



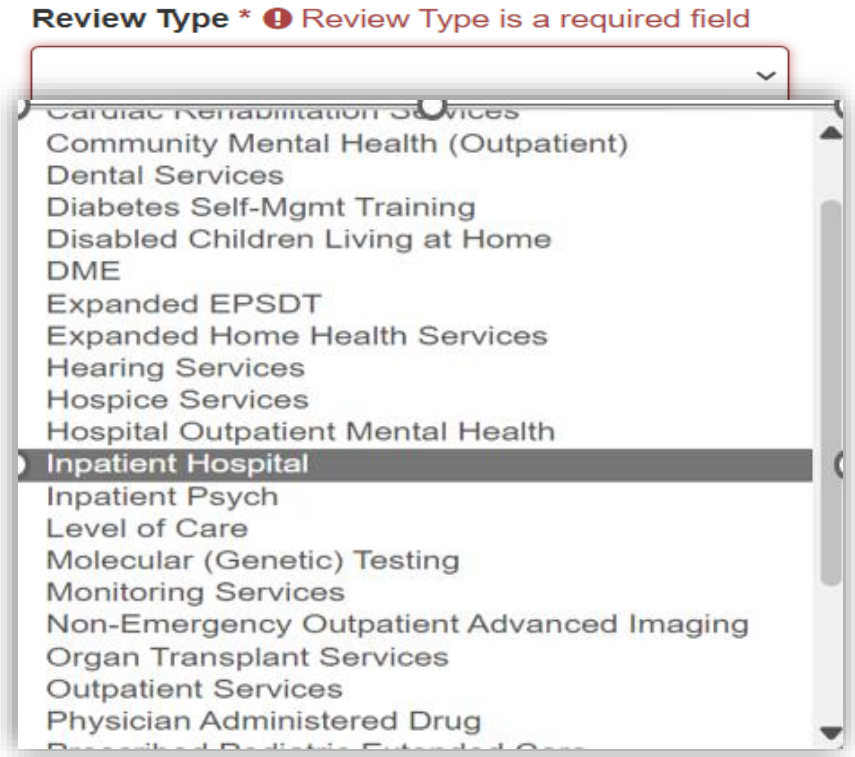
Telligen Provider Portal – Required sections

The following panels will be required for your request:

- **Authorization Request**
- **Dates of Service**
- **Coverage**
- **Providers**
- **Provider Organization Visibility**
- **Diagnosis**
- **Procedures**
- **Documentation**

Authorization Request Panel- Review Type

- Enter the **Review Type**: This is where you will select the type of review you are requesting.
  - The review appropriate for this include: Inpatient Hospital
  - Content will be located under education on the website



Timings

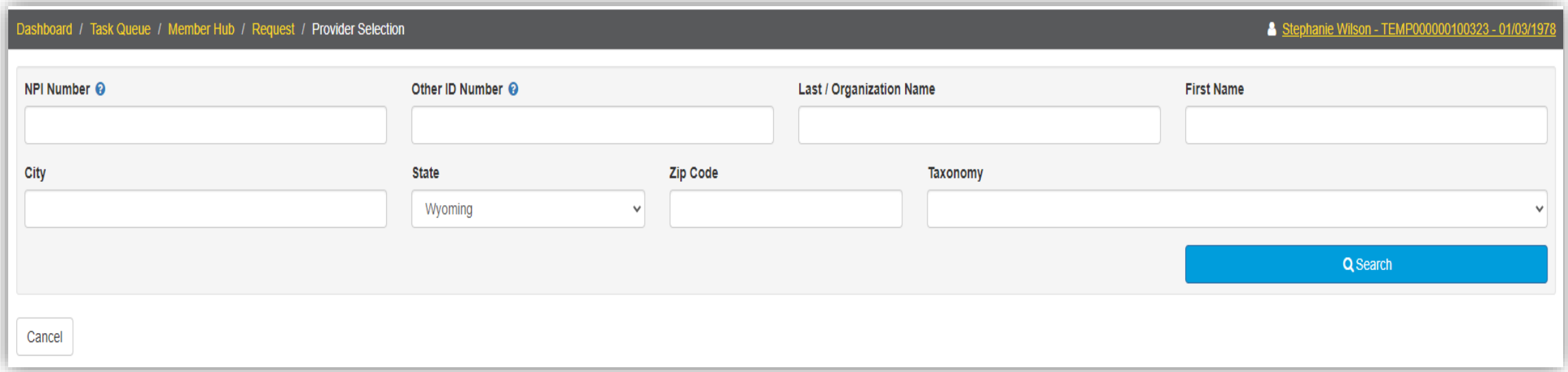
- **Prospective** – This is a review timing that is submitted prior to any services starting or before any type of inpatient stay. The requested start date must be in the future.

- **Concurrent** – This is the first review that is submitted if services have started. The requested start date should be the day of the request.

- **Retrospective** – This is a review timing that is submitted after all services have been provided. The start date and the discharge/end date should both be prior to the request date.

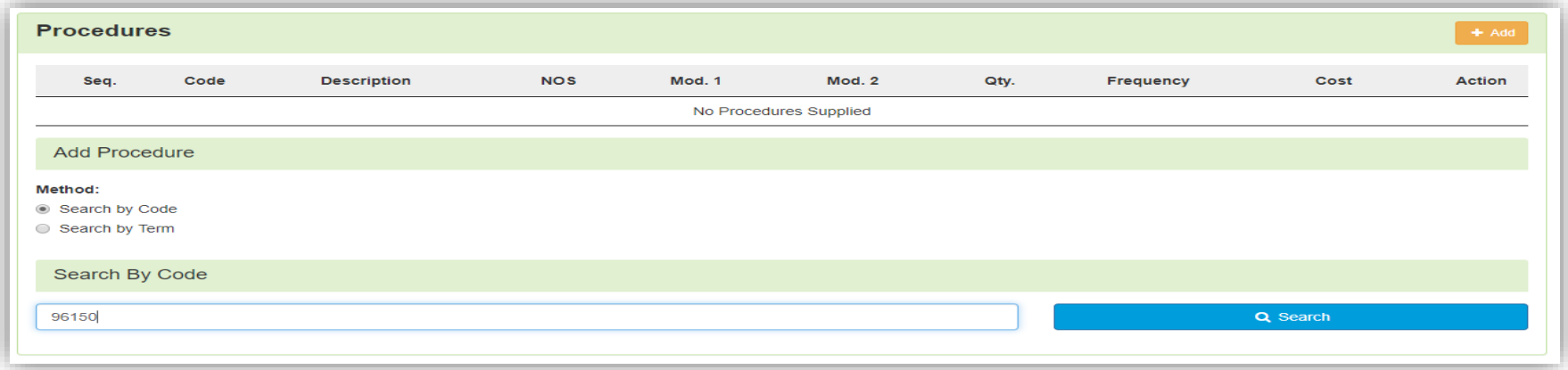
Entering Physician and Facility Information

- Clicking + Add will open a search box. You can search by entering an NPI number or **Medicaid ID** 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.



Procedure(s) Panel

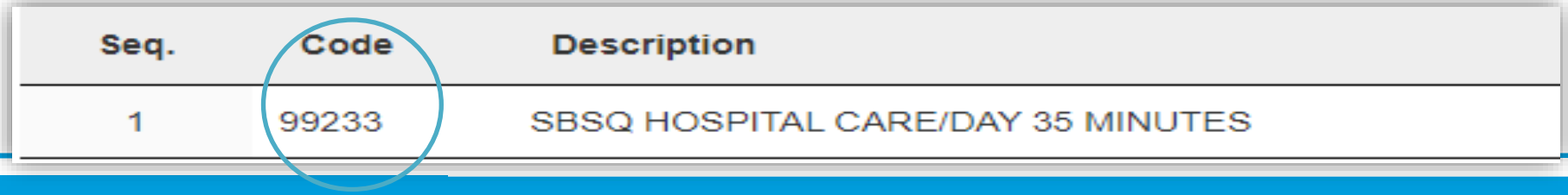
- The **Procedures Panel** is where the procedure code information related to this review is added.
- Click the + Add button to add a new procedure to the panel.
  - Select Radio button to indicate a code or term search
  - Enter information in the search box
  - Click search



Procedure(s) Panel cont.

- The Term search allows for the user to search based on Section, category and sub-category if needed

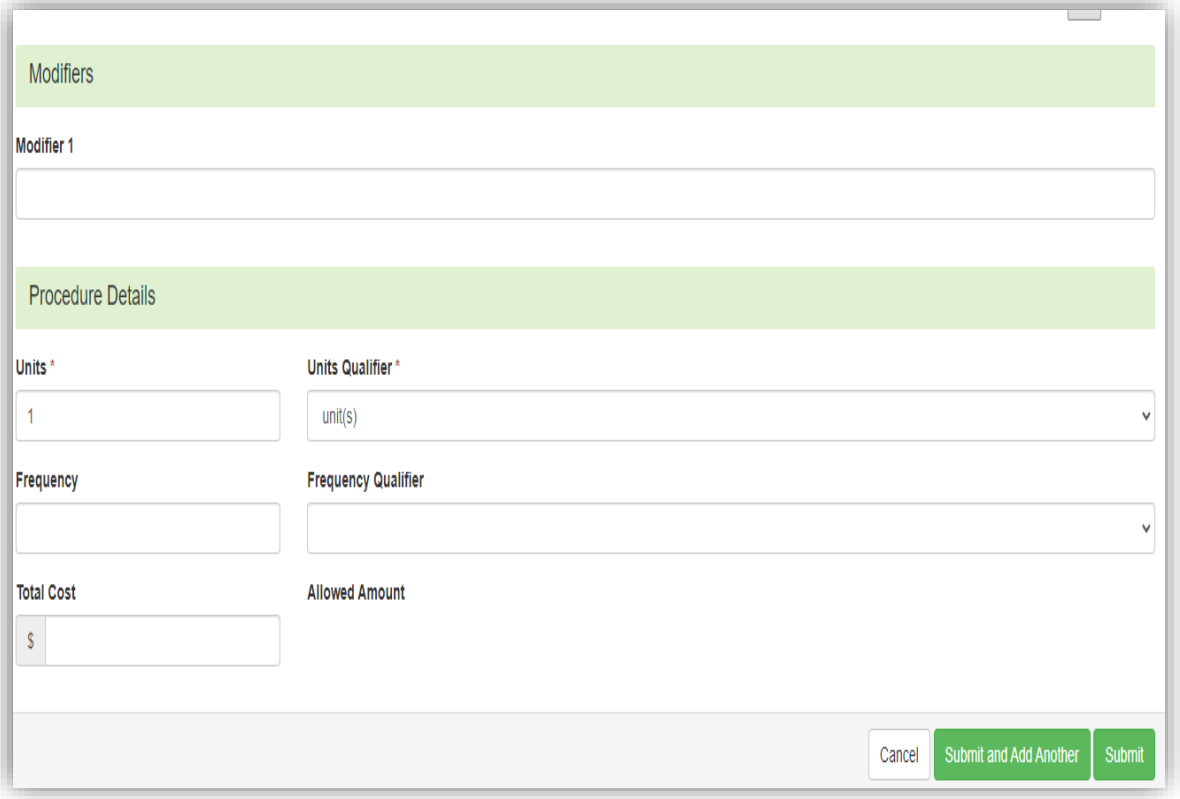
- Once Query has populated, Use the radio button to Select the correct Procedure(s) (**99233**-This is the default code for this review type).



Seq.	Code	Description
1	99233	SBSQ HOSPITAL CARE/DAY 35 MINUTES

Procedure(s) Panel cont.

- Complete Modifiers and procedure details as needed



After selecting the procedure(s) you want added to the review:

Submit will add the procedure to the review.

Submit and Add Another will allow you to submit the procedure to the review and re-open the window where you can search for another procedure

Enter as many procedures as needed.

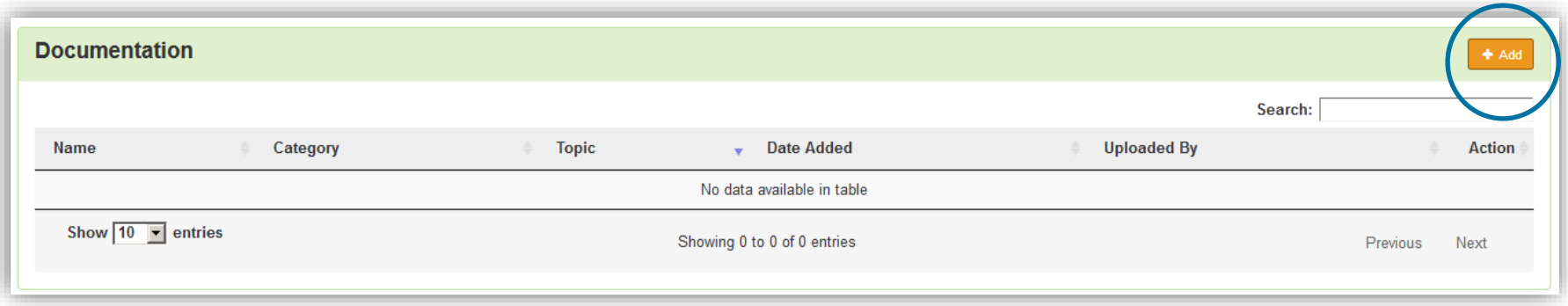
Note: Modifiers are not required by the system, but PA should match what you expect to submit on your claim

Procedure(s) Panel cont.

- Use the trash can icon on the right side of the procedure to delete anything entered incorrectly in this panel.
- Prioritize the procedures using the drag and drop features.

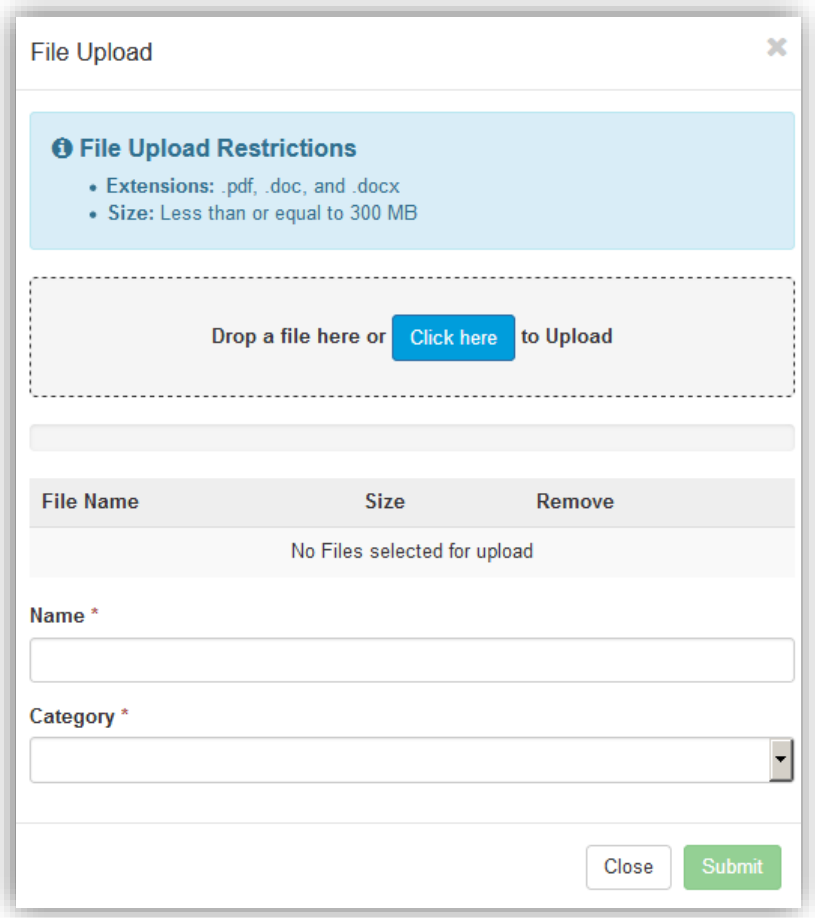
Documentation Panel

- **Documentation Panel** is the final panel on the page to submit the review.
- This is where you can upload any clinical documentation related and necessary for the review to be processed.



Documentation Panel cont.

- To submit documentation, click the button on the Documentation Panel. This will open a modal where you can drag and drop files or select Click here to open a windows directory and find the necessary files.

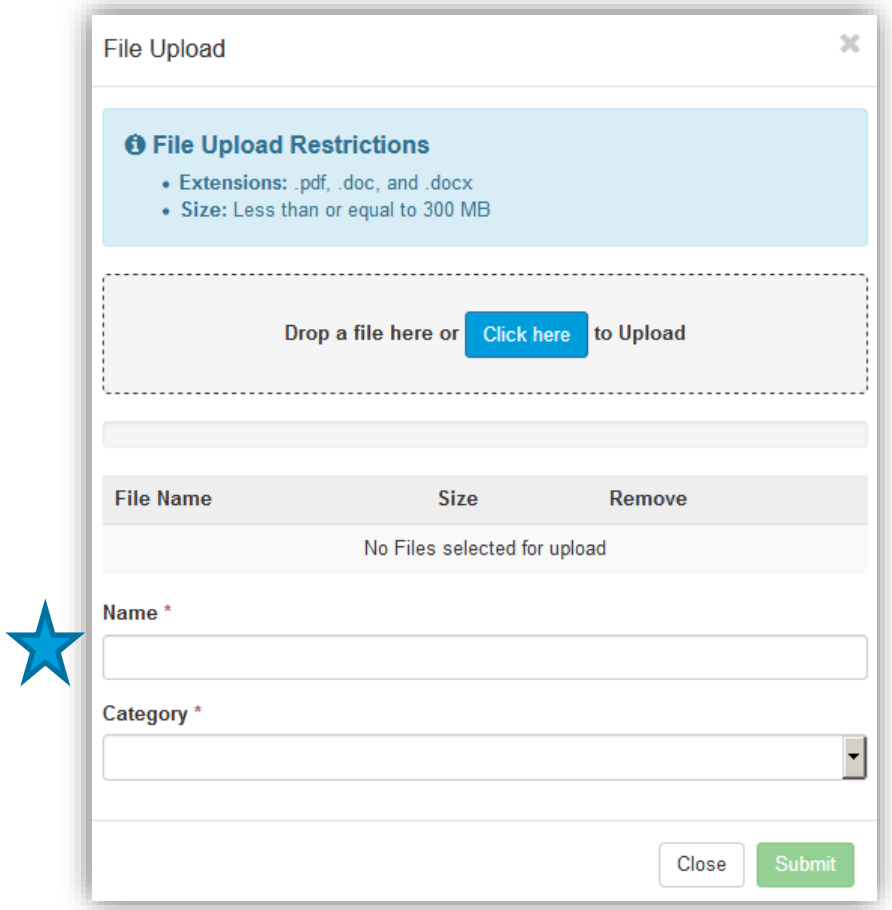


Documentation Panel cont.

- Please note:
  - Documents must be a .pdf or word document
  - The size is limited to 300MB per document.

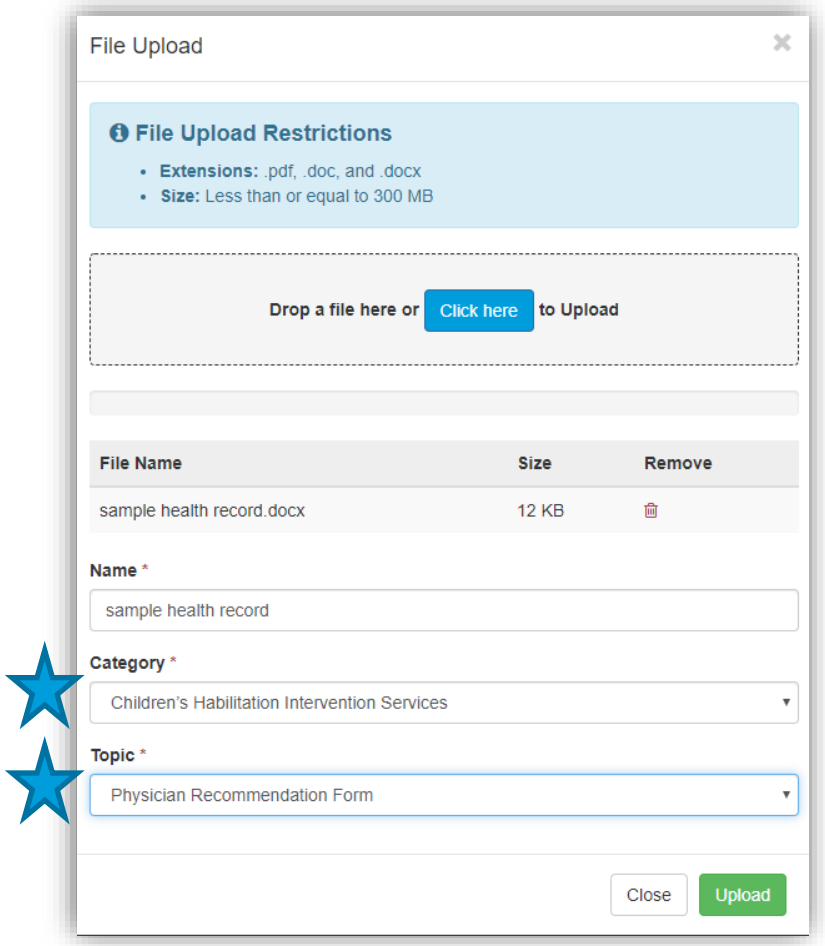
Complete the File upload fields

- **Name**:
  - The **Name** box allows you to name the file to what makes sense, if needed
  - The file name cannot have any spaces or special characters.



Documentation Panel cont.

- **Category**:
  - select from the drop down the type of document that you are attaching.
- **Topic**:
  - Select from the drop-down type of document being attached.
- Click Upload to attach the information to the review.
- **NOTE:** This can be repeated as many times as necessary to get all relevant documentation added.



Required Documentation

Prospective/Concurrent

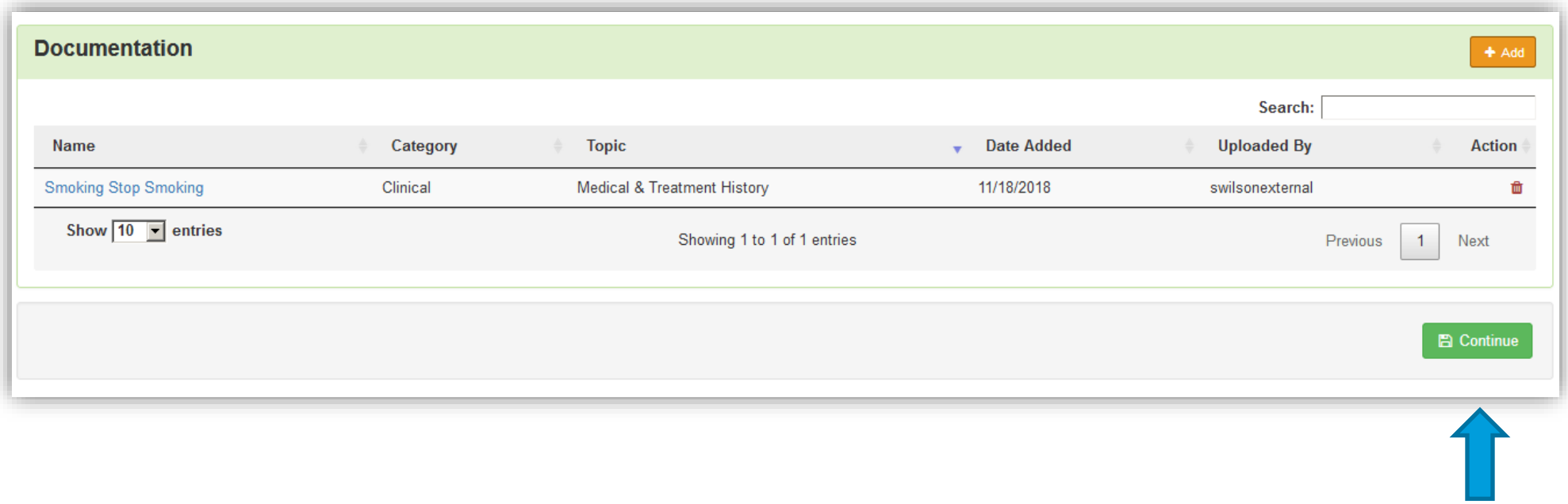
- Emergency room notes and/or admission assessment
- Physician Orders

Concurrent/Continued Stay

- Dates of service
- Comprehensive History and physical
- Diagnoses
- Diagnostic studies and results
- Documentation of any consults
- Medication listing including route, dose frequency and indication
- Discharge planning and instructions
- Discharge orders
- Signed orders
- All imaging results

Completing your Review

- Once all the panels have been filled out, click Continue in the bottom right of the page to complete the review.

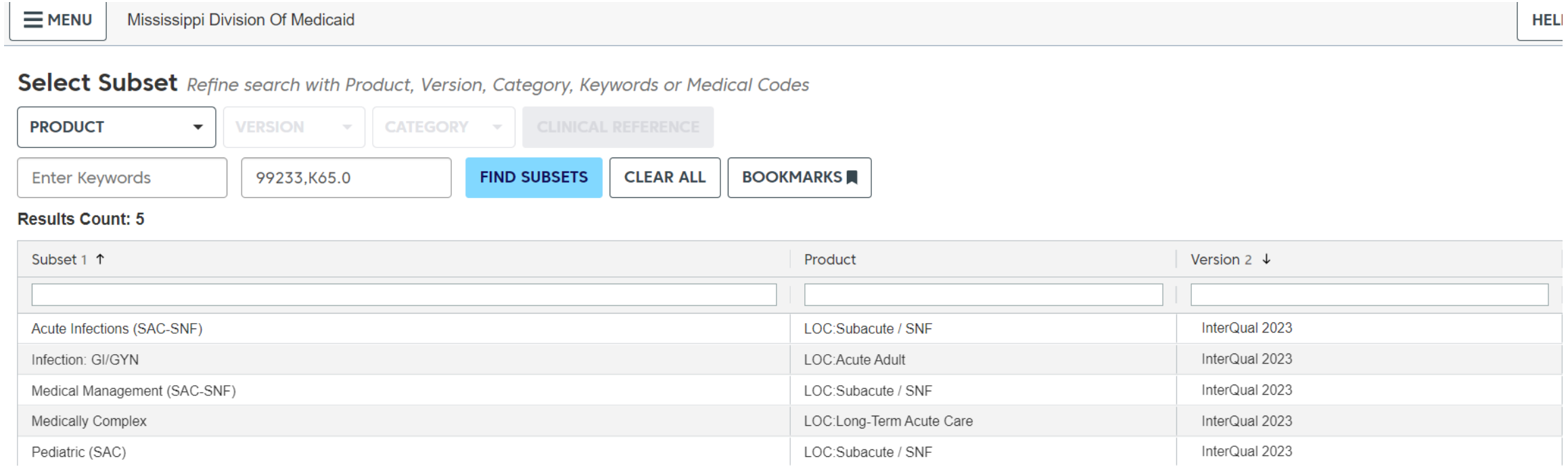


Criteria

- **The criteria being used is NOT changing at this time.**
- Telligen will be using InterQual criteria for Acute Inpatient reviews.
- You will need to document against that criteria as part of your submission process.

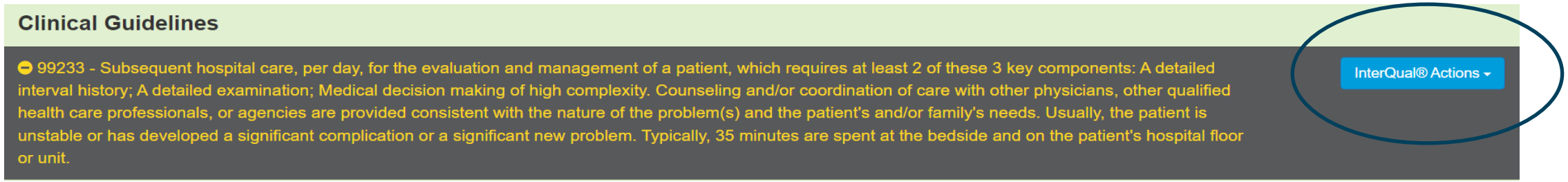
InterQual Process

- InterQual is integrated into Qualitrac to provide transparency into the clinical guidelines and criteria we use to review your authorization requests
- The system automatically takes the end user through the InterQual process



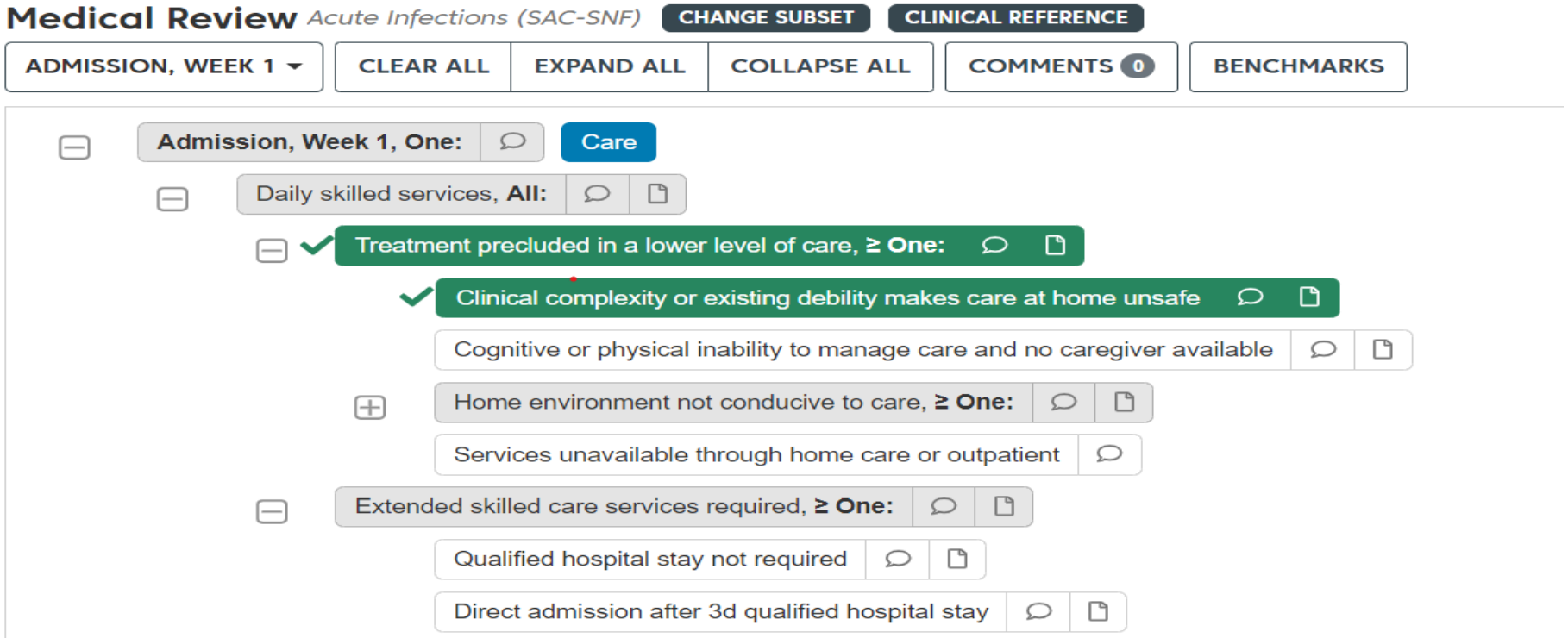
InterQual Process cont.

- If there are clinical guidelines that apply, you will see the procedure or diagnosis with a Guideline Title line and the user will select the InterQual Action button to document which criteria are present.
- Select all that are relevant and choose save once all information has been entered.



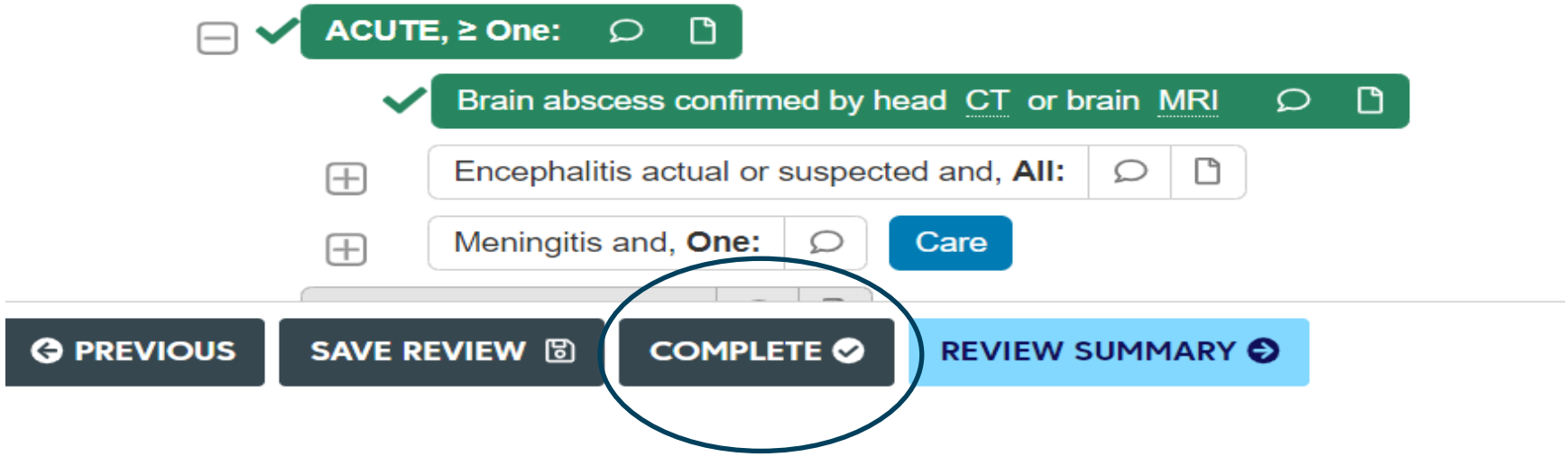
InterQual Process cont.

- Select the guideline.
- Click all criteria that apply.



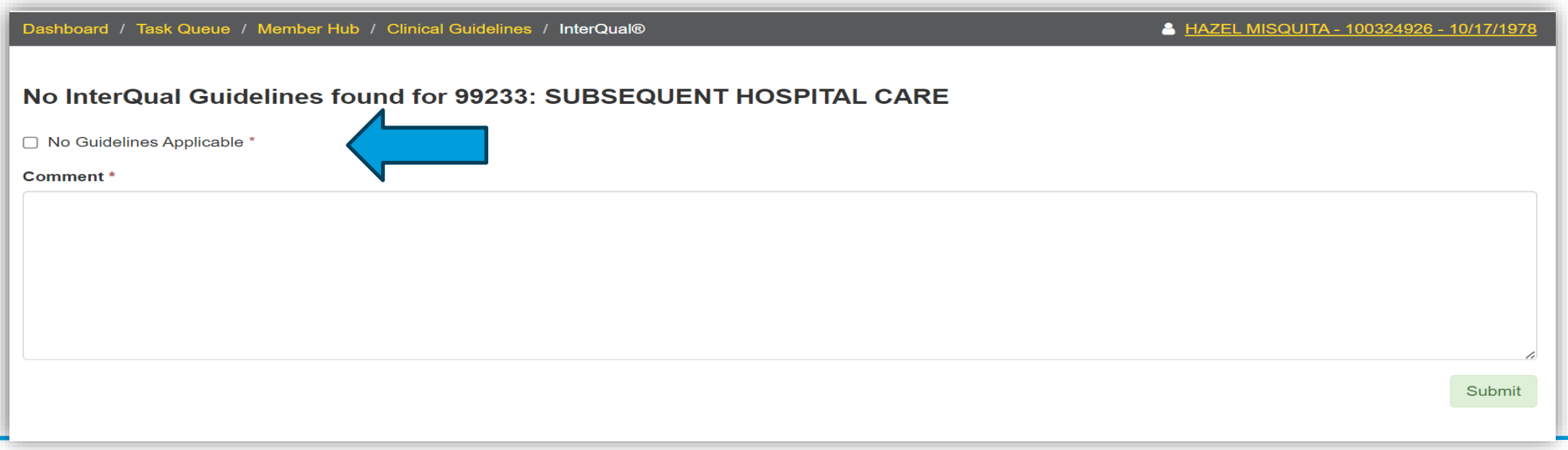
InterQual Process cont.

- Once all documentation is entered, click the **Complete button** to finish this section and return to finalizing the review.



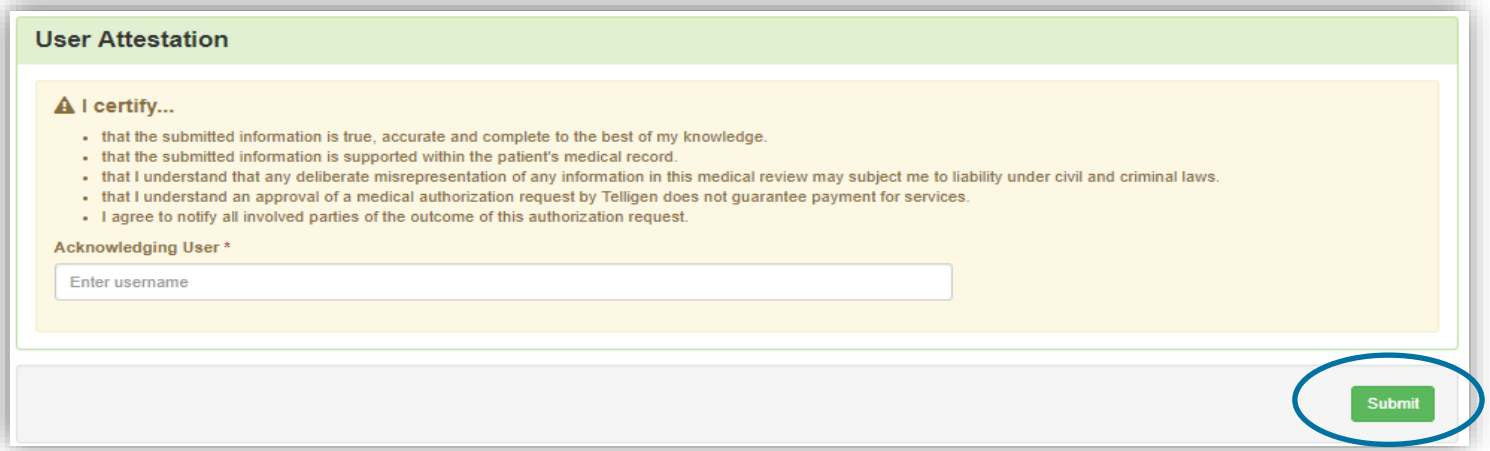
InterQual Process cont.

- 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.

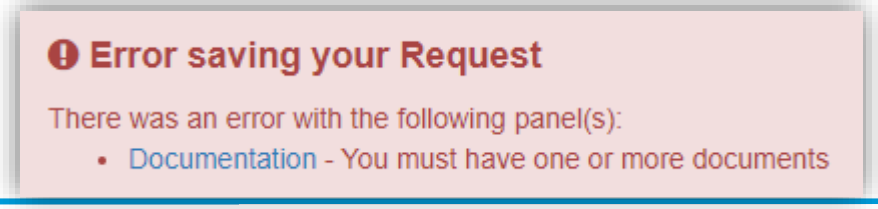


Attestation

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

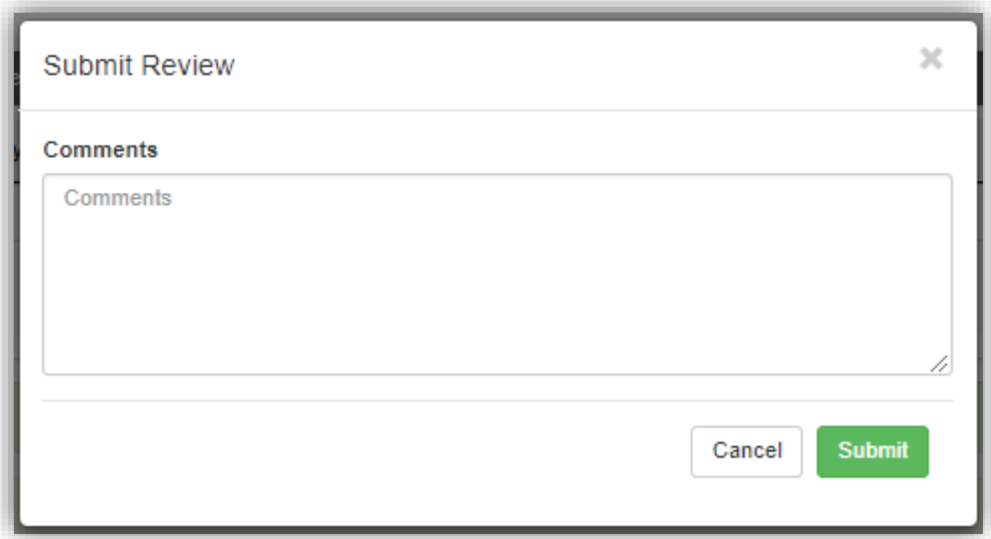


- Click the Submit button to send the review to Telligen
- If any information is missing, an error will indicate what is missing



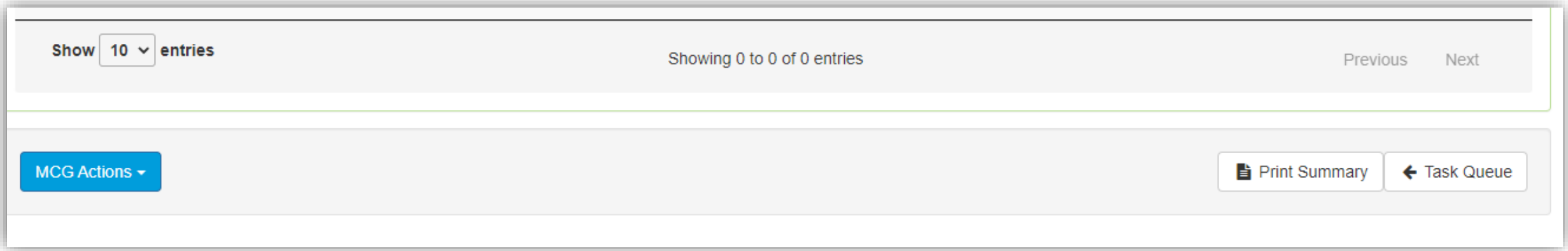
Comments

- 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**.



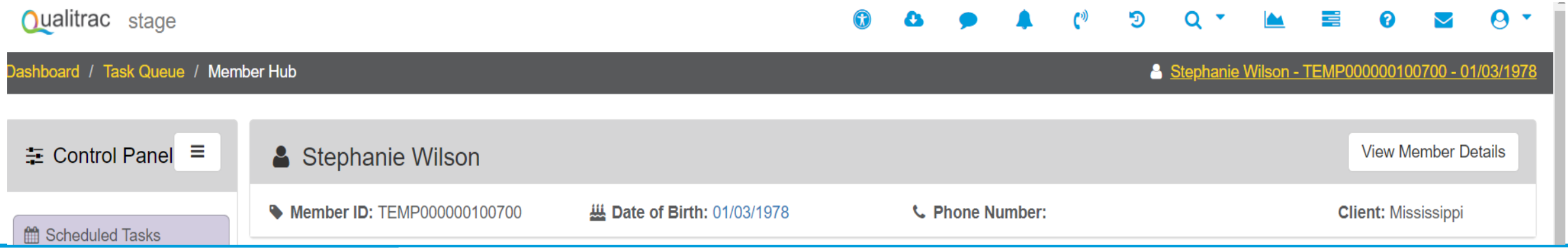
Summary

- After submitting you will be taken to a summary of the review
- Users will have the option to Edit or Delete via the Actions button
- To navigate off of the request, scroll to the bottom of the page and select Task Queue
  - This will return the user to the tasks page where you can begin a new search and submit other reviews.



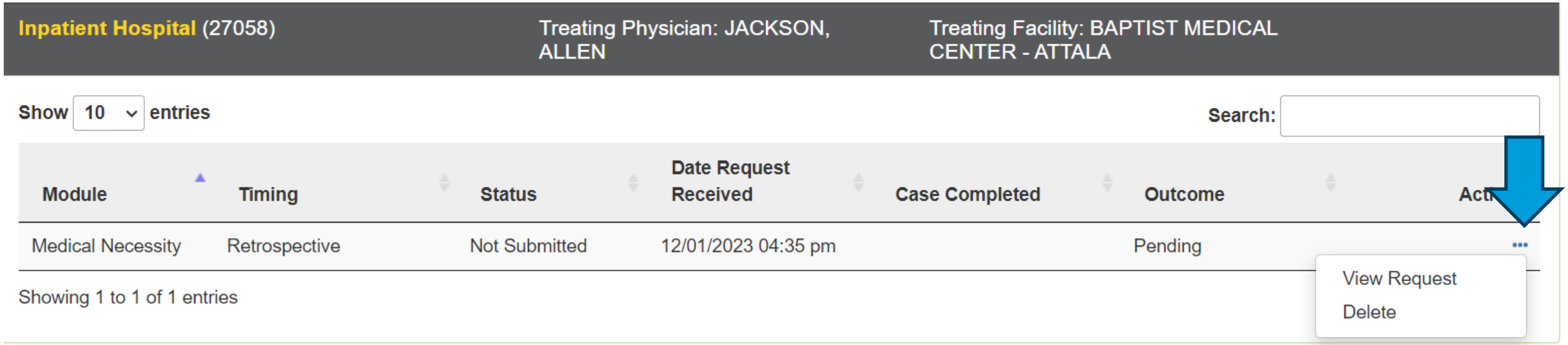
Where Did My Review Go?

- Once a review has been submitted, you can find the review by:
  - searching for the Case ID
  - searching for the member and looking at the UM panel in the Member Hub.
- **Member Hub functions**:
  - Allows the user to look at the Review to check for determination and any correspondence
  - Submit a Reconsideration which is titled 1st Level Appeal
  - Delete a review that was submitted incorrectly



Review

- Once in the **UM Panel**:
  - Navigate to your request
  - Click on the ellipsis at the right side of the line request. This menu will allow you to view the request in more detail, submit a reconsideration (1st Level Appeal), and other options.



Request for Information (RFI)

A Note about Timeframes

Telligen Review Timeframes

Prospective	Concurrent	Retrospective
1 Business Day	1 Business Day	20 Business Days

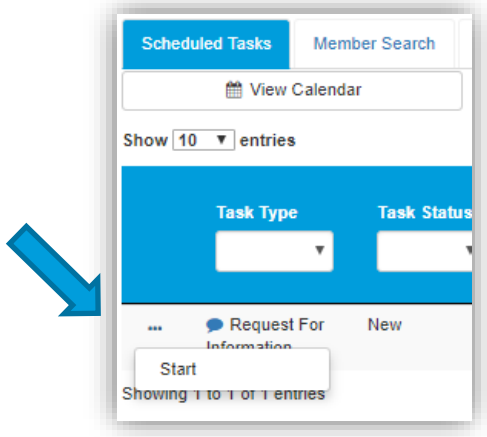
Provider Timeframes

- Providers have 10 business days to respond to a request for information (RFI).
- Providers have 30 calendar days to submit a reconsideration.
- Providers should enter reviews for urgent or emergent admissions on the next business day after the admission.

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

Request for Information

- When a reviewer needs additional clinical documentation to make a determination, the submitter 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.

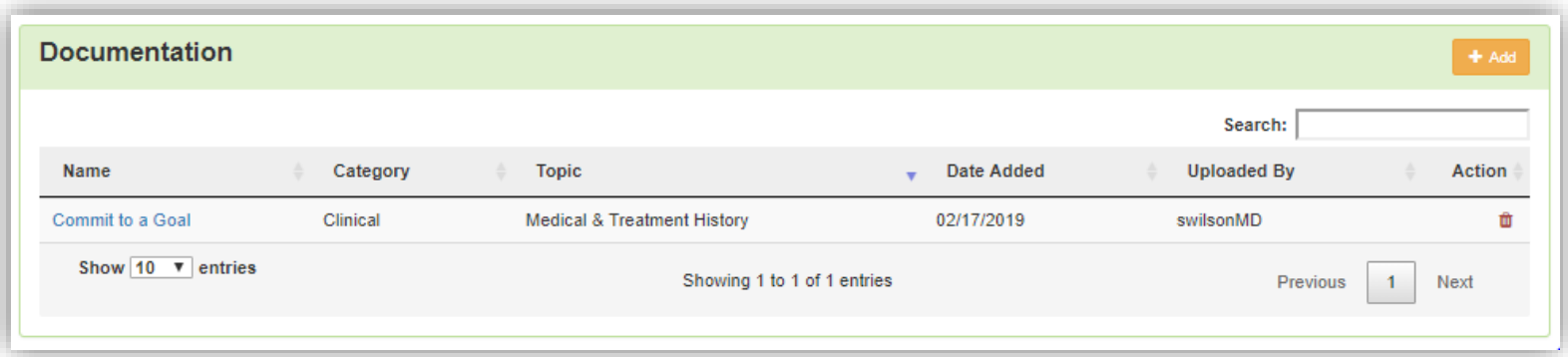


Request for Information

- 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.



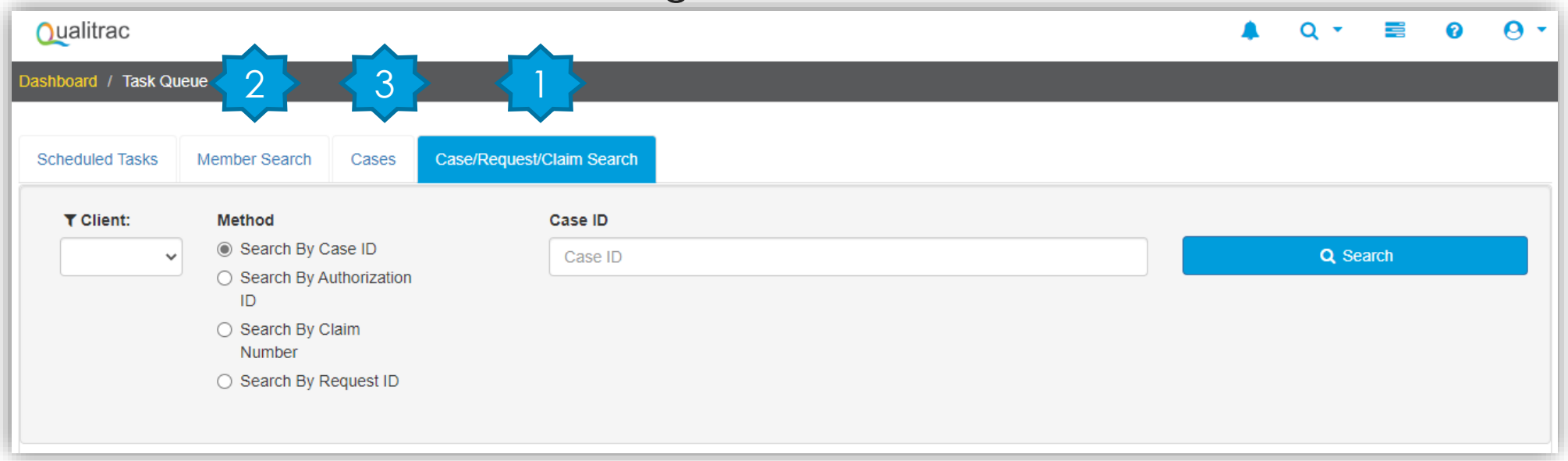
Request for Additional Information

- 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.

Finding the Determination

Locating A Determination

- **To Locate the determination**: Log in and select search under UM

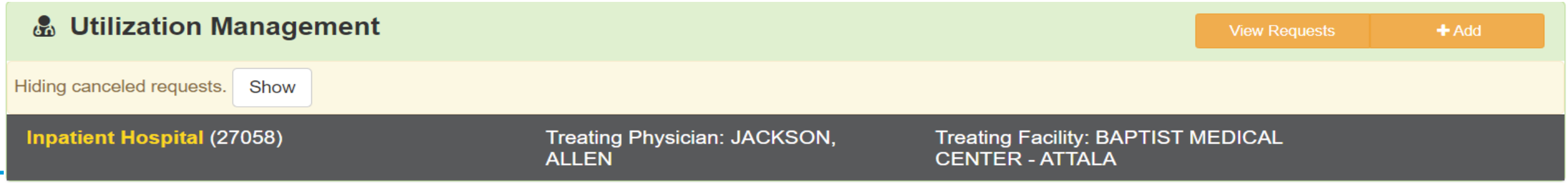


Locate the member

1. Search for the case by using the case ID
2. Search by the member and locate the case in the member hub
3. Search Cases for the list of all auth requests

Locating A Determination

- To **Locate the determination**:
  1. If searching by the member, once in the member hub:
     - Scroll down to the Utilization Management section
     - Select the appropriate auth request (if multiple are present)
     - Click on the ellipsis on the right side of the page in line with the review you are searching for
     - Select View Request
  2. If searching by Case ID
     - Upon selecting the case ID, you will be taken directly to the authorization request
  3. If Searching by the case list, you will scroll to locate the case and select
  4. Once the review is open, scroll down the page to the Outcomes panel
  5. Click on the gray section of the panel to open it and view the details.



View Outcome

Utilization Management

View Requests | + Add

Hiding canceled requests. Show

Inpatient Hospital (35817) Treating Provider: MICHAEL E STEUER MD PC — Complete

Show 10 entries Search:

Module	Timing	Status	Date Request Received	Case Completed	Outcome	Action
Medical Necessity	Prospective - Extension	Request Is Complete	12/13/2023 04:46 pm	12/13/2023	Approved	•••

View Outcome

Outcomes

Review Outcome: Denied

(HCPCS) G0446 - ANNUAL FCE--FCE INTENSV BEHV TX CV DZ IND 15 MIN

Outcome: Denied

Requested		Final Recommendation	
Outcome		**Outcome**	Denied (Clinical Denial)
Authorization Number		**Authorization Number**	7000000004
Start Date	06/13/2022	**Start Date**	06/13/2022
End Date	07/13/2022	**End Date**	07/13/2022
Modifier 1		**Modifier 1**	
Modifier 2		**Modifier 2**	
Units	20 unit(s)	**Approved**	0 unit(s) (Denied: 20)
Frequency	3 Three times weekly	**Frequency**	3 Three times weekly
Total Cost		**Total Cost**	
		Letter Rationale: denial	

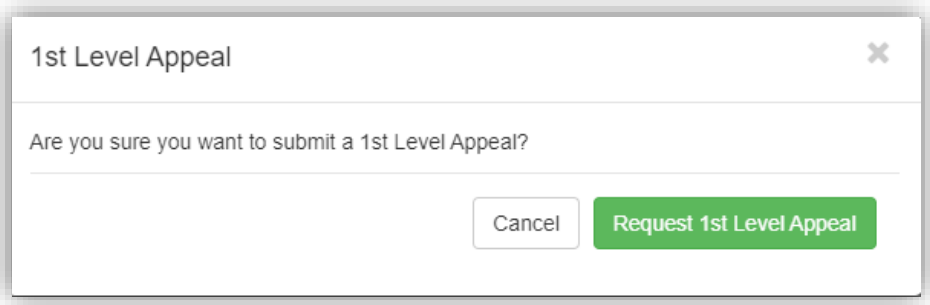
Submitting a Reconsideration (1st Level Appeal) or P2P Review

Submitting a Reconsideration (1st Level Appeal)

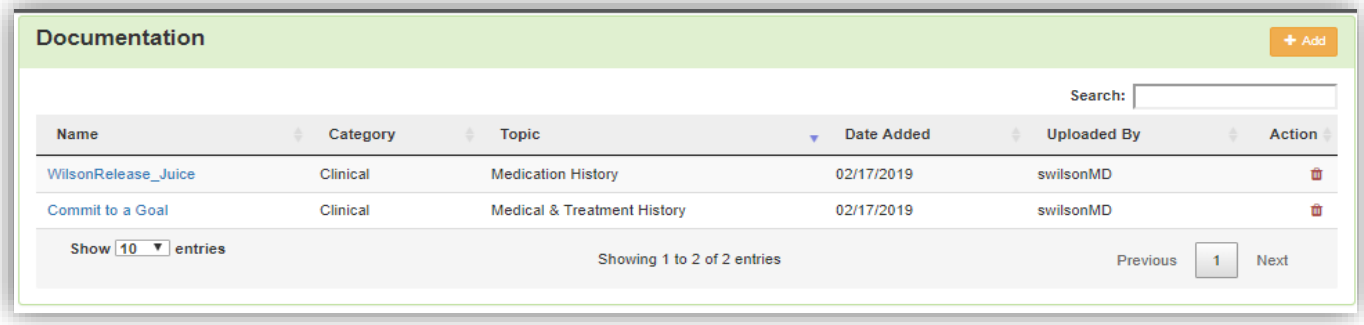
- To submit a reconsideration for a denied review:
  - Go to the **UM panel** in the member hub
  - Click on the blue ellipsis within the denied case to open the action menu
  - Once there, select **1st Level Appeal** from the menu.

Reconsideration (1st Level Appeal) cont.

- The system will ask you if you are sure you want to submit a 1st Level appeal
- Select the green button : **Request 1st Level Appeal**
  - You will still be able to delete the request later



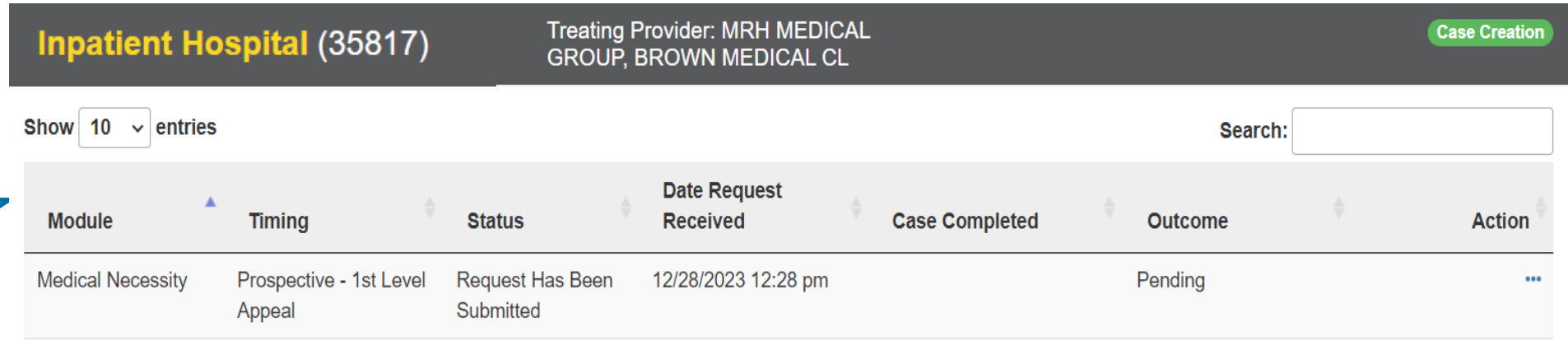
- Attach any additional documentation that is necessary to support the appeal



Reconsideration (1st Level Appeal) cont.

- Sign the User Attestation using your **USER ID**

- Click Submit to have the information sent to Telligen for reconsideration



The system will display your appeal

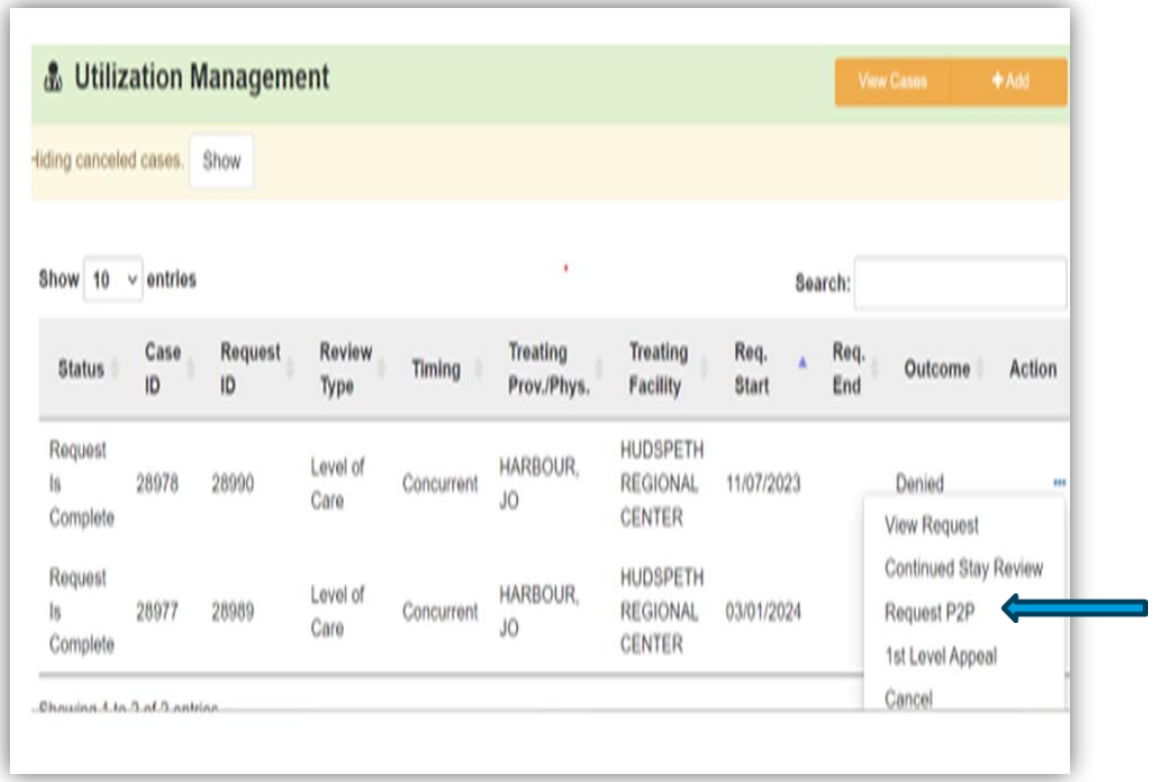
Peer-to-Peer Review

If the reconsideration determination was upheld or any portion was not approved as requested, the provider can request a *Peer to Peer Review*. A second physician not involved in the initial decision reviews the reconsideration request, the original information, and any additional information submitted. The provider will have 30 calendar days from the date and time of the initial determination being rendered to submit the request.

Written notification will be provided of reconsideration determinations within 10 business days of receipt of the request for a standard reconsideration.

Peer to Peer cont.

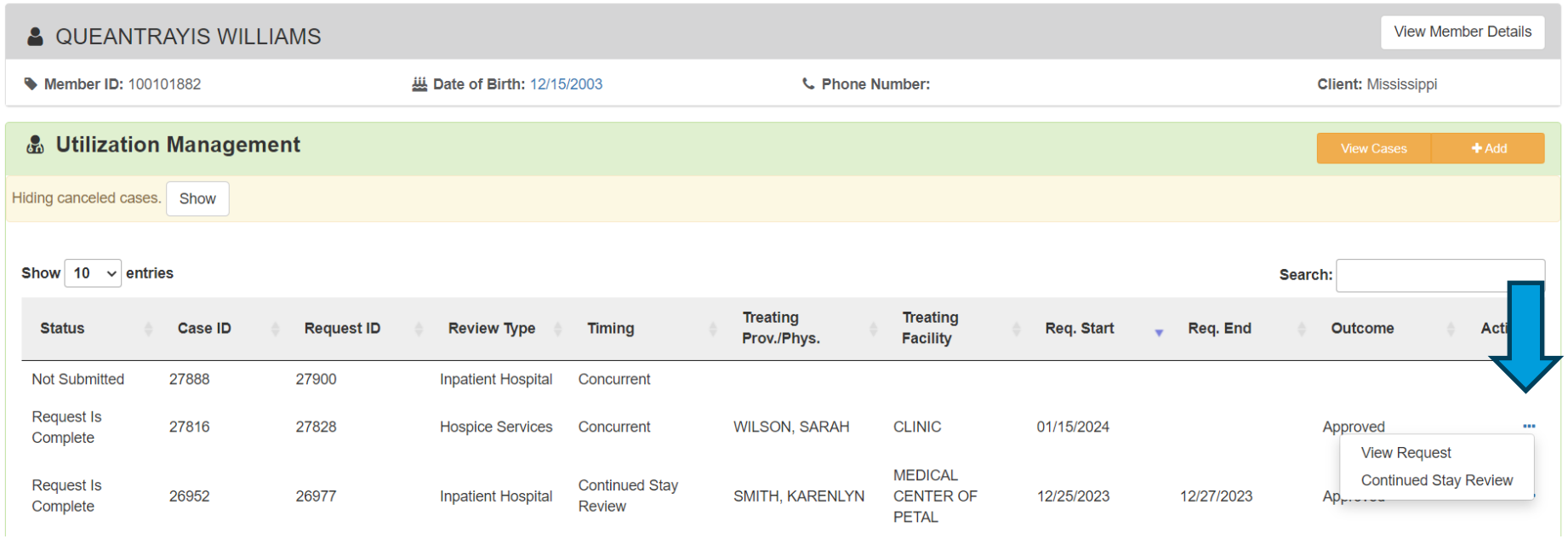
- **Submitting a Peer to Peer**: 1. Go to the UM Panel in the member hub 2. Click on the denied review 3. Click on the blue ellipsis within the denied case to open the action menu. 4. Once there, select Peer to Peer from the menu. 4. Follow the system prompts to complete. 5. If the provider desires to request a peer-to-peer via phone, they need to call Customer Service at 1-855-625-7709. They will need the case or member ID when they call in and the customer service rep will be able to create the task in the system. A representative will contact the requesting provider with scheduling details within five business days of making the request.



Continued Stay Review

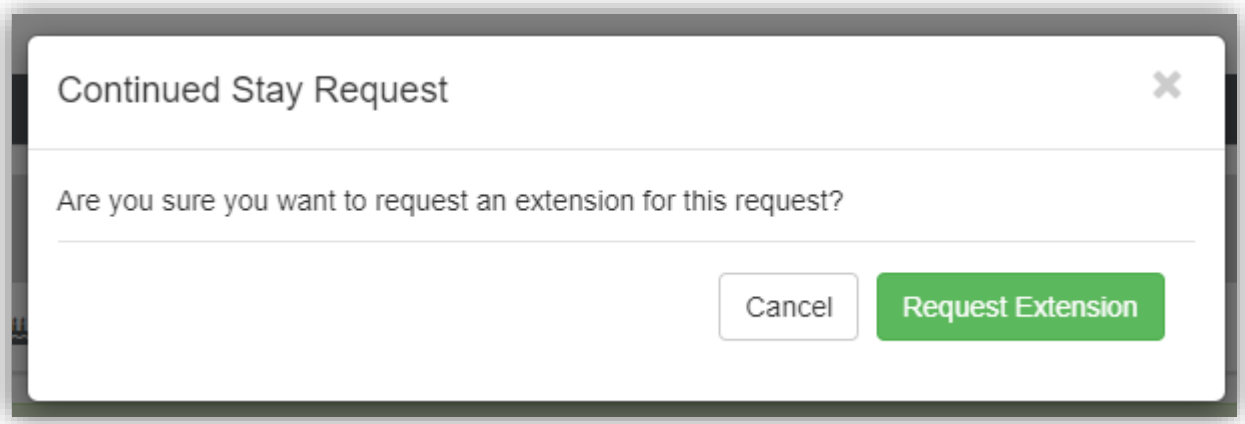
Continued Stay Review

- To submit a **Continued Stay Review** for an admission review:
  - Go to the UM panel in the member hub
  - Click on the blue ellipsis within the case to open the action menu
  - Once there, select **continued stay review** from the menu



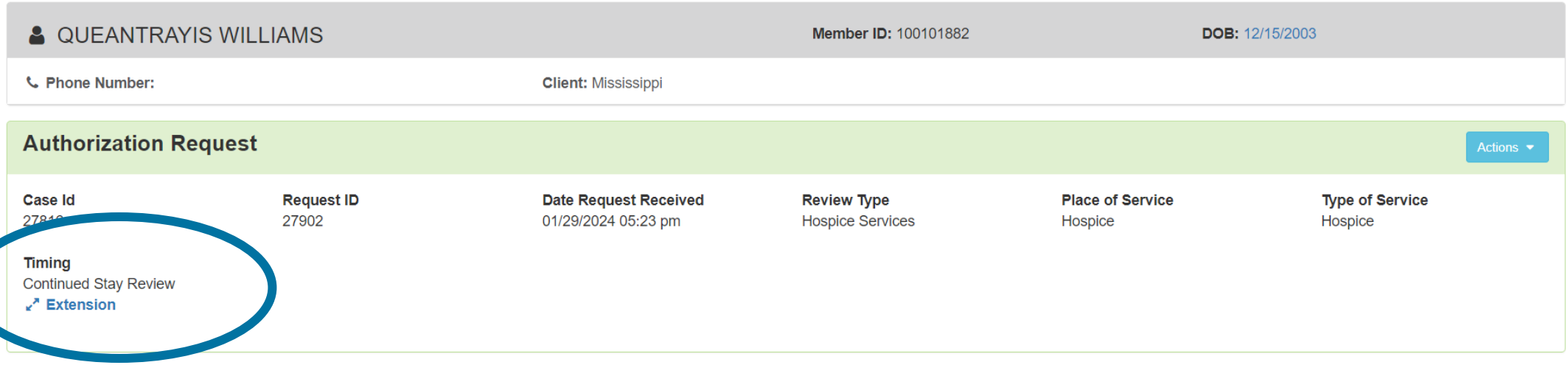
Continued Stay Review

- The system will validate that you want to request an extension
- Click the green button for **request extension**
- If this was done in error, click cancel



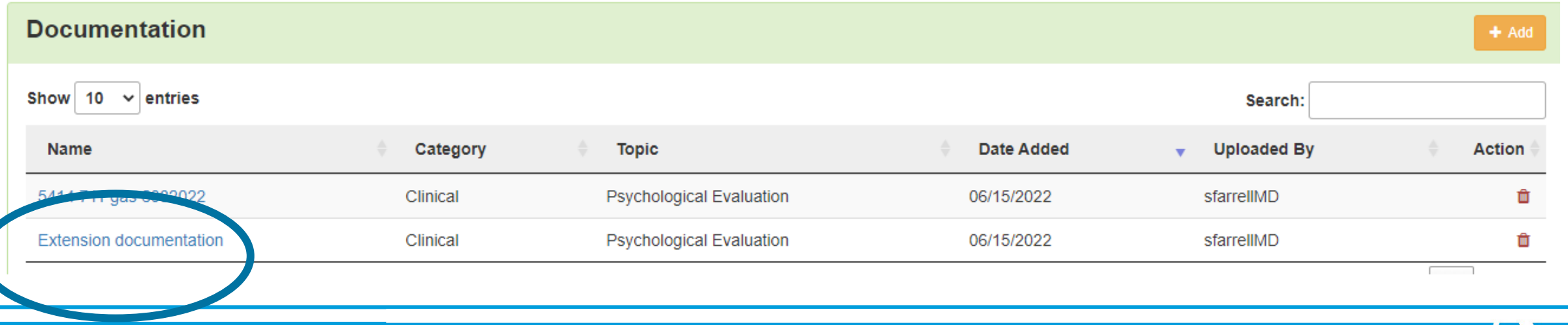
Continued Stay Review

- The system user will be directed to update and complete the extension request
- The timing section of the **Authorization Request panel** will indicate you are completing a continued stay review extension



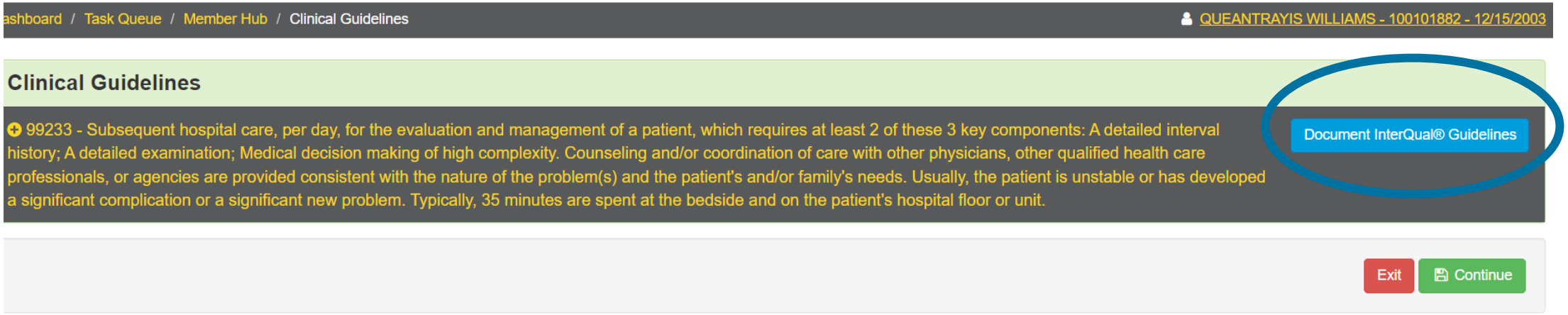
Continued Stay Review

- The User will review all the panels and update appropriately
  - Update any new diagnosis to support the extension in the diagnosis panel
  - Provide supporting documentation in the Documentation Panel to indicate the need for an extension
  - Click **Continue**



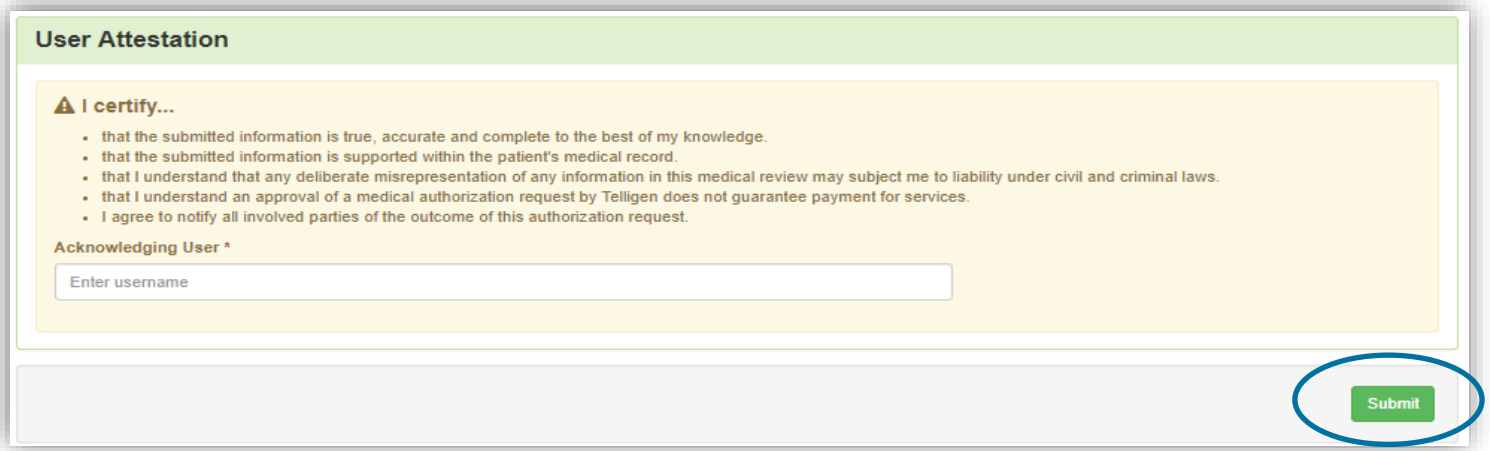
Continued Stay Review

- The User will need to repeat the InterQual process:



Continued Stay Review Attestation

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

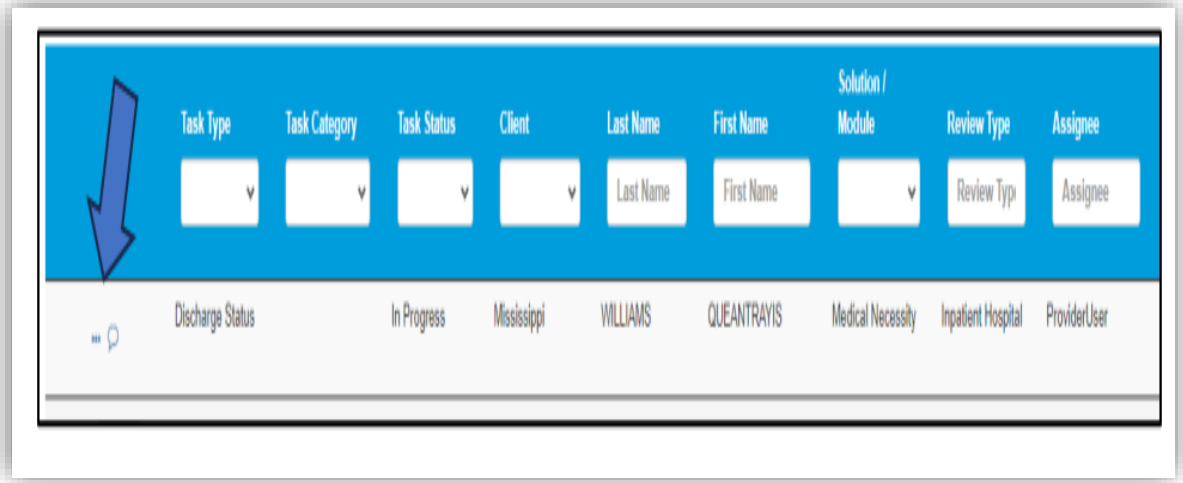


- Click the **Submit** button to send the review to Telligen
- Await a response for the extension request

Discharge Information Task

Discharge Information Task: For specific requests, a provider 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.

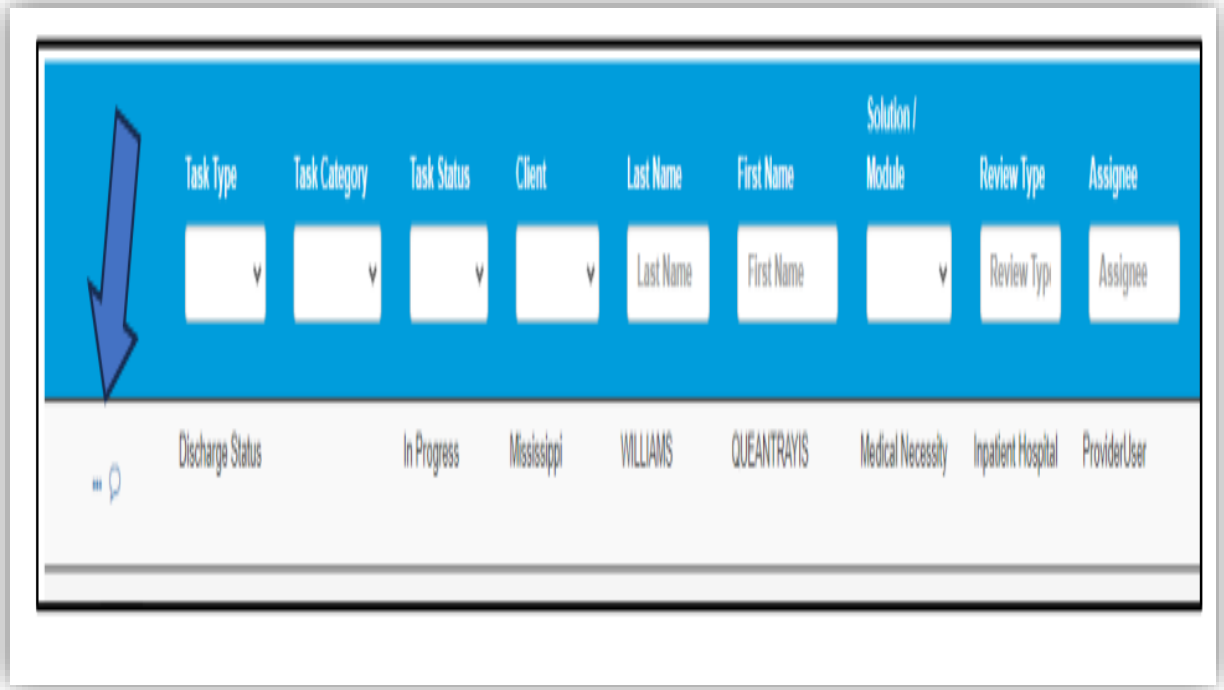
If an extension of stay (CSR) is submitted, the task will be removed and a new task will be displayed once the Continue Stay Review has been completed.



Discharge Information

Starting the Discharge Task To submit a discharge for a review: 1. Users may start the task by clicking on the ellipses for the action menu and selecting "start" to be directed to the Authorization Request screen. Note: If the task has been started, but not completed, the action menu will display the option "Resume".

Authorization Request Screen: Once the task is started(or resumed), the provider will see a limited view of the authorization request screen. The following information will be displayed: Authorization Request case information, Discharge, Diagnosis, and Documentation panels.



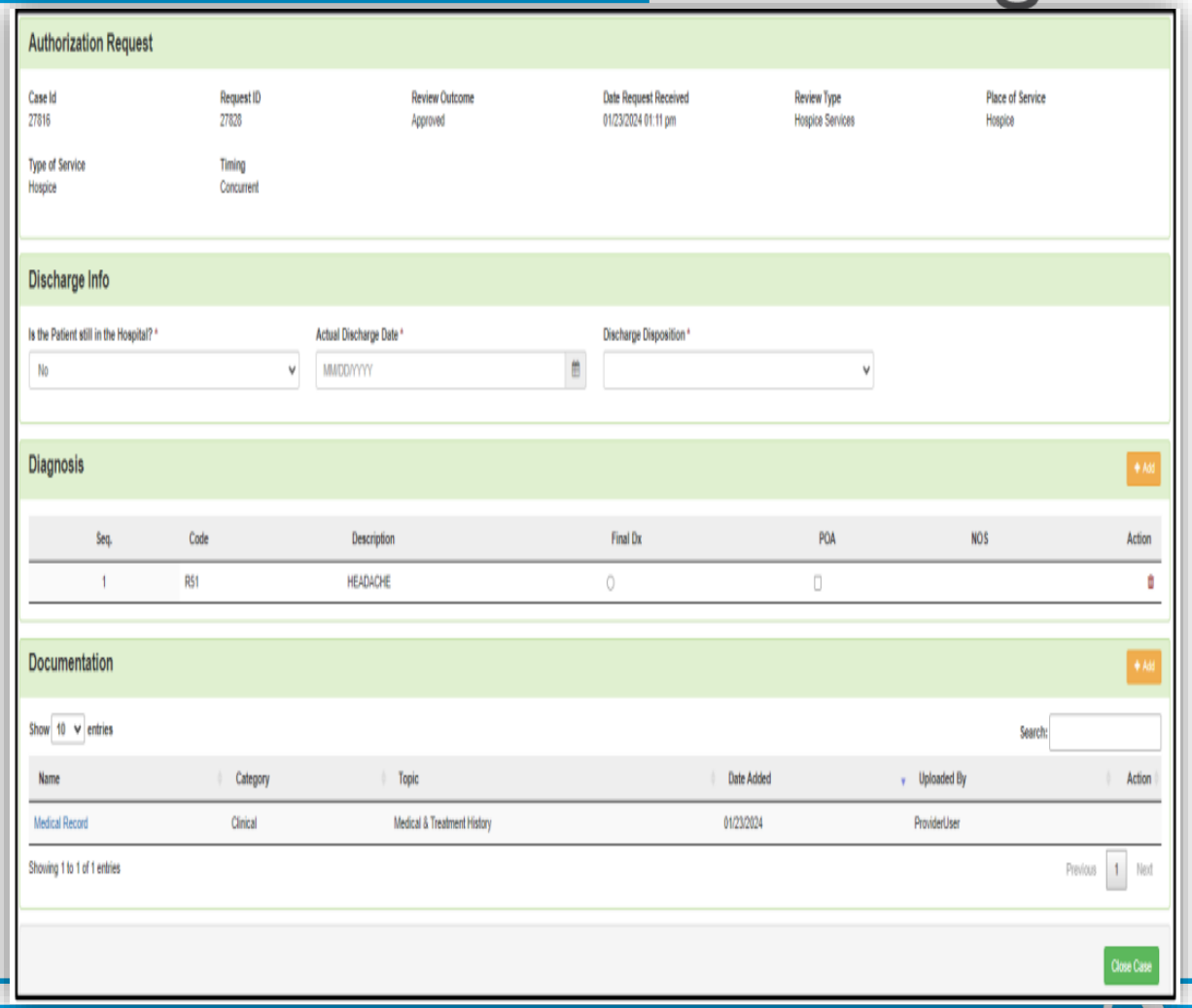
Discharge Information cont.

Discharge Panel: The user will be required to enter the following three pieces of information: indicate if the person is still in the facility, enter the actual Discharge Date, and enter the Discharge Disposition.

Diagnosis Panel: The user can update the diagnosis of the member and indicate a Final Diagnosis by selecting the radio button under Final Diagnosis. It can stay the same as the original diagnosis.

Documentation Panel: The documentation panel is where a user will upload any additional information.

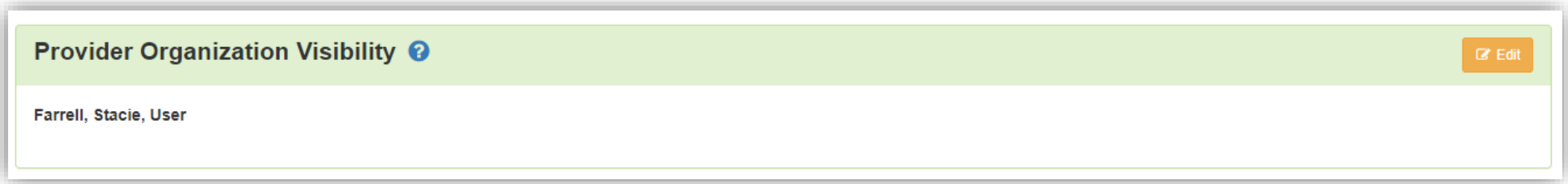
Completing the Task: Once all the information has been entered in the panels, the user can complete the process by clicking the "Close Case" button at the bottom of the page.



E-mail Notifications

- Users will receive email notifications when:
  - Reviews are received from the portal
  - Reviews are updated/changed in status

- To make sure that everyone in your organization that should receive email notification for reviews does get one, please select the organization or facility in the Provider Organization Visibility panel.



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Questions