Mississippi Medicaid:

Telligen Provider Portal Training – Advanced Imaging Services

August 2024

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
- E-mail notifications
- Questions

Contact Us

Education Manager – Primary Point of Contact

Katrina Merriwether

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

AJae Devine

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
- 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

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

MISSISSIPPI DIVISION OF MEDICAID

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Important:

Instructions on how to register for the portal: click here

DocuSign Tip Sheet: click here

The portal will not be accessible until January 16, 2024. The activation link and password are only good for 7 days.
Emails regarding login information will not be sent until the week of January 9, 2024.

Qualitrac Login

Web application used by healthcare providers to submit clinical care requests for review

LOGIN

Provider Portal Registration

New users need to register to gain access to Qualitrac. Registration takes less than 10mins.

REGISTER

FREQUENT QUESTIONS

CHECK REVIEW STATUS

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 glass at the top of the page.
- **Portal** will take you to the portal or to the task queue.

Utilization Management

| ▶ Start Tasks | 🔍 Search | ⚙ Portal |
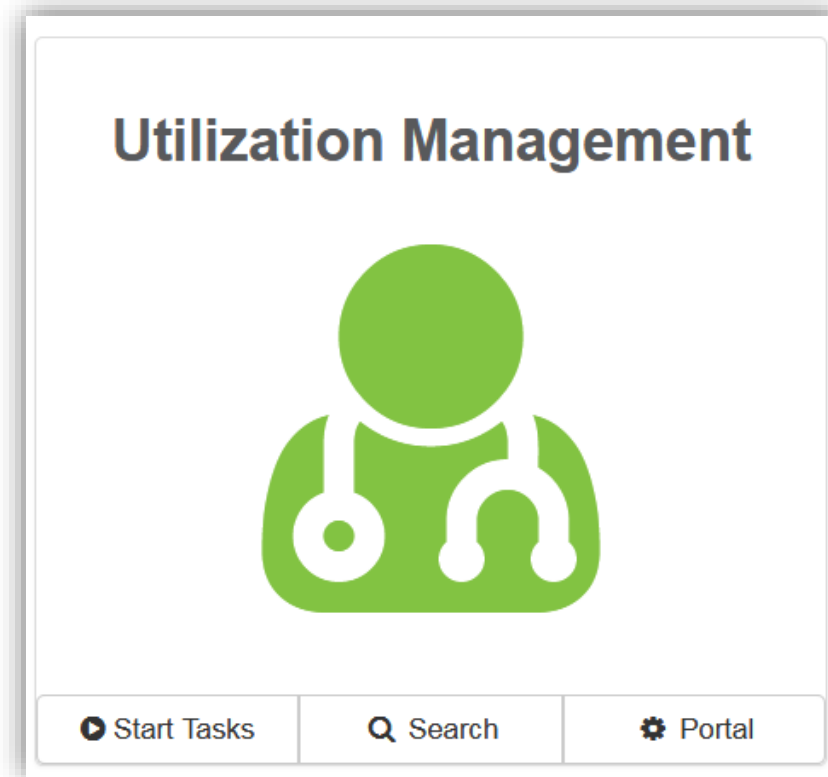
Submitting a Review

Advanced Imaging Prior Authorization

An authorization is required for the following, except when it occurs in inpatient hospital, emergency room or outpatient hospital 23hr observation period:

- CT and CTA scans

- MRI/MRA

- PET Scans

- Nuclear Cardiac imaging studies

Prior auths must be submitted by either the ordering or rendering provider.

Telligen Provider Portal – Adding a New Review

How To Locate a Member:
- Enter the Member's ID and Date of Birth
- Enter the member's First Name, Last Name and Date of Birth

- NOTE: The Member ID and the Date of Birth must match with what is on file in the MESA system to locate the member information or to begin a new review for that member.

Telligen Provider Portal – Adding a New Review

- The member(s) matching the criteria entered will populate
- Select the appropriate member
  - Click on any of the data fields in blue to access the member information or to start a new review for the member.

Telligen Provider Portal – Adding a new review

- **The Member Hub:**
  - The Telligen Provider Portal allows you to view information related to this member based on rights of your role.
  - You will be able to see their contact information
  - You will be able to see any reviews that have been submitted for them on behalf of your organization.

Stephanie Wilson   View Member Details

Member ID: TEMP000000100700   Date of Birth: 01/03/1978   Phone Number: Client: Mississippi

Utilization Management   View Cases   + Add
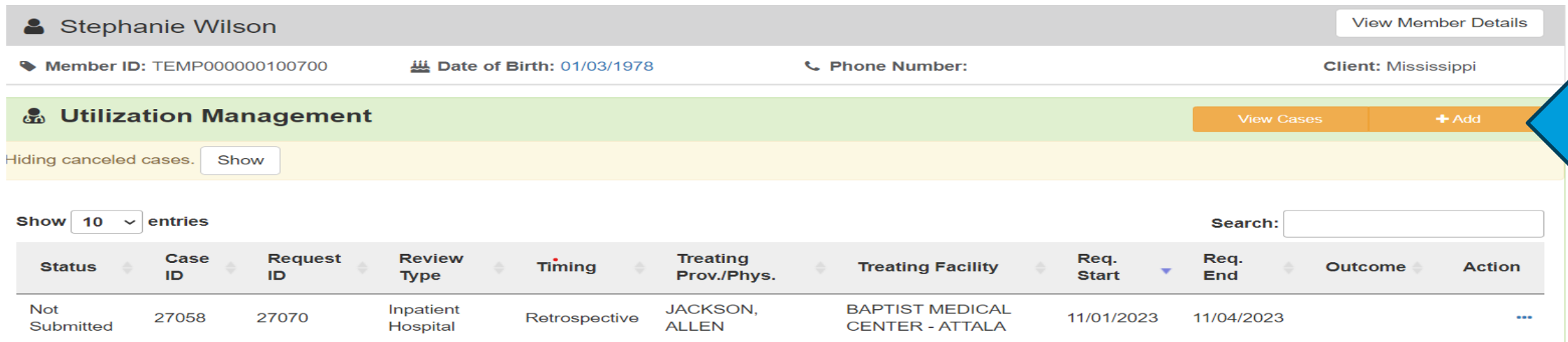
Telligen Provider Portal – Utilization Management Panel

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**

We will review each of these sections

Telligen Provider Portal – Add New Request

To begin a new request, fill in the **Authorization Request** panel.

- Date will prepopulate with the current date

Authorization Request Panel- Review Type

- Enter the **Review Type**: This is where you will select the type of review you are requesting:

  – Non-Emergency Outpatient Advanced Imaging

Review Type *

Diabetes Self mgmt Training
Disabled Children Living at Home
DME
Expanded EPSDT
Expanded Home Health Services
Hearing Services
Hospice Services
Hospital Outpatient Mental Health
Inpatient Hospital
Inpatient Psych
Level of Care
Molecular (Genetic) Testing
Monitoring Services
Non-Emergency Outpatient Advanced Imaging
Organ Transplant Services
Outpatient Services
Physician Administered Drug
Prescribed Pediatric Extended Care
Private Duty Nursing
Psychiatric Residential Treatment Facility Services
Substance Abuse Disorder Services

Authorization Request Panel cont.

- **Place of Service**: This is where you will select the place where care is being given.
- **Type of Service**: This Is the type of service being requested.
- **Timing:** This is where you will select Prospective, Concurrent or Retrospective
- Select **Add New Request** to complete the process.
  - If the request was entered in error, you can select Cancel to remove the request

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.

Retrospective Requests

A retrospective review may be requested if:

- The request is submitted within 3 business days from the date of service

- If the patient faces immediate risk of loss of life or limb

- Waiting for an authorization could seriously jeopardize the life or health of the beneficiary

- The beneficiary would suffer severe pain that could not be managed without the procedure

Dates of Service Panel

- Once you select Add New Request, the page opens to fill in all the remaining information necessary to process the request.
- **Dates of Service Panel** is used to enter the Service Start Date and the Service End Date

Coverage Panel

- The **Coverage Panel** will detail information about the member's eligibility.

- The Medicare Indicator and Third-Party Liability will default to No/Not Supplied unless there is information from MESA stating that the member has Medicare or other insurance.

⚠ **Member Not Eligible**

This member appears to either not meet eligibility requirements or has multiple coverage plans. We cannot confirm eligibility for the entire span of care. Please provide rationale for continuing with this request.

Group	Section	Plan	Start Date	End Date
		No Coverage Found		

Medicare Indicator *

Yes

Third Party Liability *

No

EPSDT Indicator *
○ Yes ◉ No

Eligibility Comment *

Coverage Panel cont.

- There is an Eligibility comment box where you can enter information related to the member's eligibility.

- This will also allow the submitter to override lack of eligibility for those member's whose eligibility may be at a future date and the request is being submitted in advance.

Medicare Indicator *

| Not Supplied ⌄ |

Third Party Liability *

| No ⌄ |

EPSDT Indicator *

○ Yes   ● No

Eligibility Comment *

NA

Providers Panel: Physician and Provider Information

- **Providers:** This section requires information related to who is ordering and providing the care:
  - *Ordering Provider-* The person or Organization ordering the care
  - *Treating Provider –* The **organization** providing the care

★click the Add button on each box to fill in the necessary provider information

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.

Stephanie Wilson - TEMP000000100323 - 01/03/1978

NPI Number ❓

Other ID Number ❓

Last / Organization Name

First Name

City

State
Wyoming

Zip Code

Taxonomy

🔍 Search

Cancel

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 aligns to the services being requested

Taxonomy				
				Search:
Primary ▲	Taxonomy	State	License Number	Source
PRIMARY	2084N0400X - Psychiatry & Neurology			Client File

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

	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

Entering Physician and Facility Information

- You will see the physician's name or facility name and information populated in the corresponding panel.
- You can access the delete button by clicking the 3 dots to the right if selected in error
- You can use the **+ Add** button to search and find a new physician/facility for the one that was deleted.

Providers

Type	Name	NPI	Address	Phone	Primary Taxonomy
Treating Physician	JACKSON, ALLEN		Clinic #: 1 2351 Highway 1 S Greenville, MS, 38701	(662) 344-1817	General Practice

Provider Organization Visibility Panel
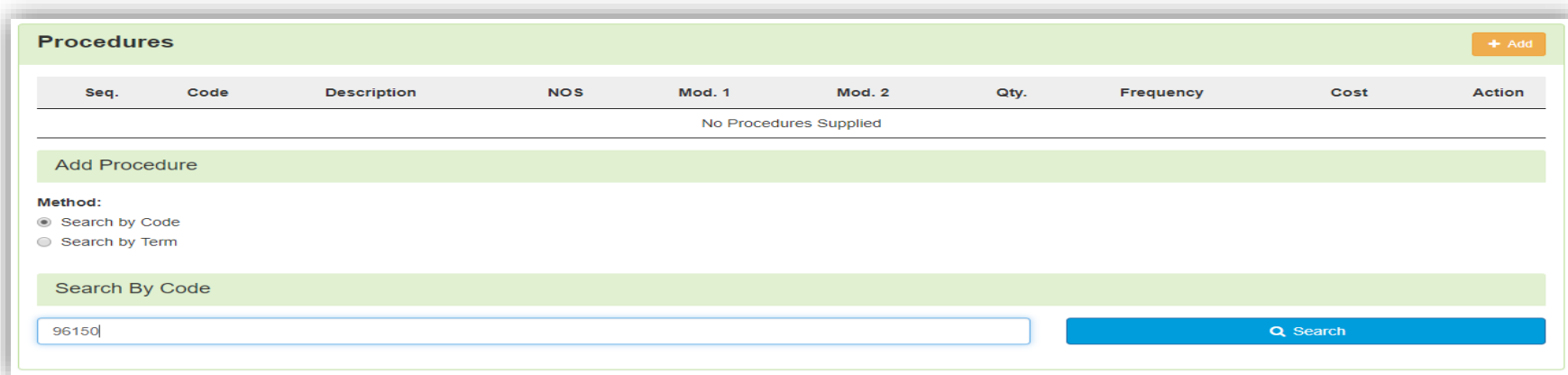
- **Provider Organization Visibility:** This box is not required but it allows you to share this review with everyone in the organization you are submitting it for.

- This will also allow you to share the review and allow visibility by the Treating Providers organization for their knowledge and information

Provider Organization Visibility ❓

Wilson, Stephanie, User

ST LUKE'S REGIONAL MEDICAL CENTER

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

Procedures									+ Add
Seq.	Code	Description	NOS	Mod. 1	Mod. 2	Qty.	Frequency	Cost	Action
				No Procedures Supplied					

Add Procedure

Method:
- Search by Code
- Search by Term

Search By Code

96150   [Q 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)

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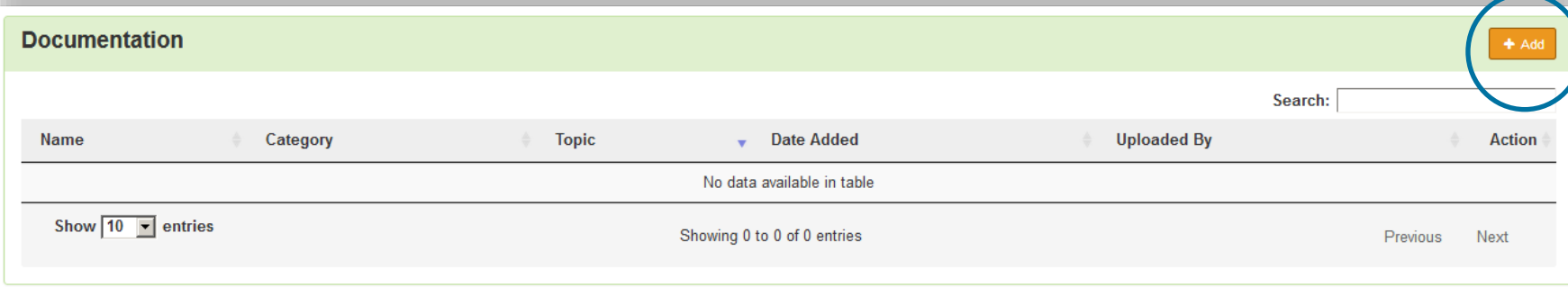
- Use the trash can icon on the right side of the procedure to delete anything entered incorrectly in this panel.
- Prioritize the procedures using the drag and drop features.

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.
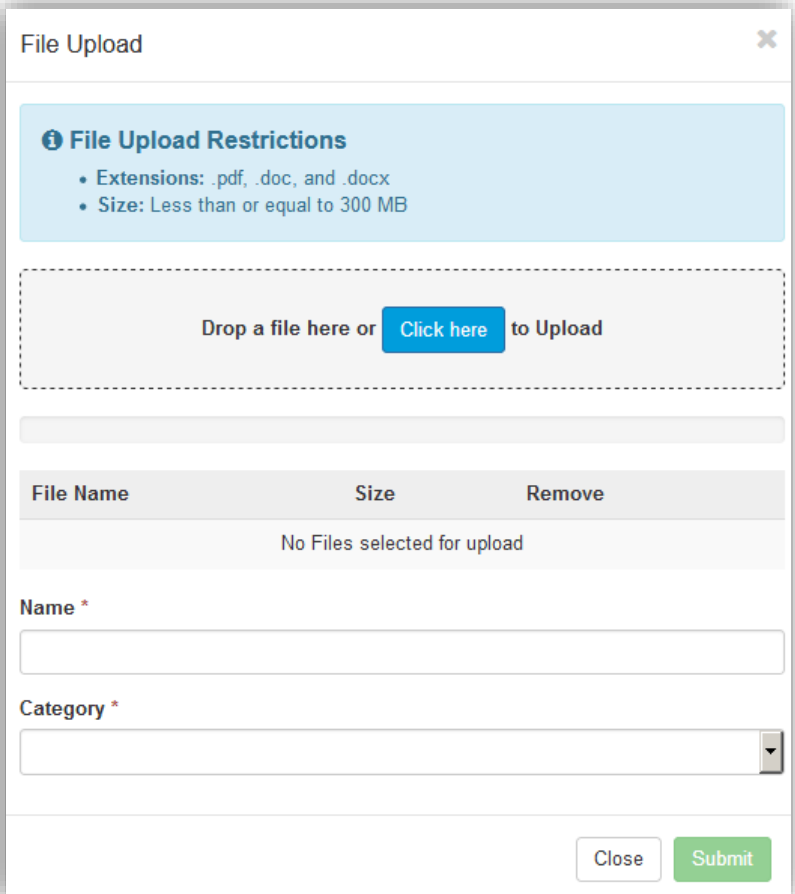
Documentation Panel cont.

- To submit documentation, click the **+ Add** 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.
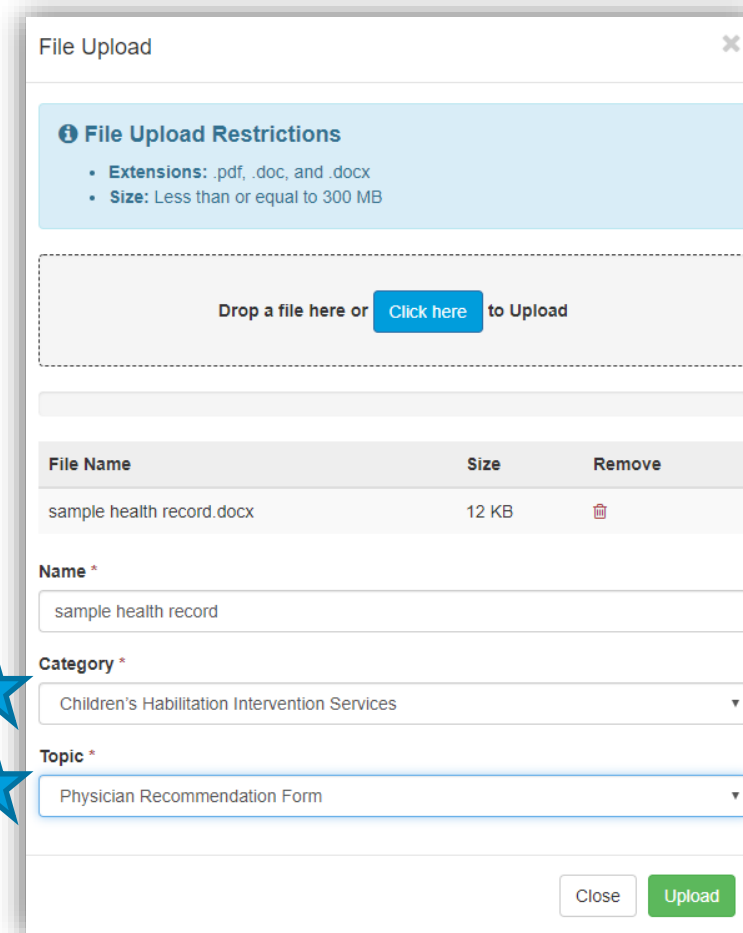
Documentation Panel cont.

- **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

Documentation must include:

- Results of recent clinical evaluation

- Diagnosis or clinical condition which the imaging eval is being ordered

- Treatment history related to the stated diagnosis or clinical condition

- Treatment plan related to the stated diagnosis or clinical condition

- Previous imaging results related to the stated diagnosis or clinical

  All documentation must include 2 patient identifiers

  For example – patient name and Medicaid number or patient name and date of birth (DOB).

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 <u>NOT</u> changing at this time.**

- Telligen will be using InterQual criteria for Advanced Imaging 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.

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

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.

No InterQual Guidelines found for 3319F: X-RAY/CT/ULTRSND ET AL ORD

☐ No Guidelines Applicable *

Comment *

Submit

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.

Clinical Guidelines

⊖ 99233 - Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

InterQual® Actions ▾

InterQual Process cont

Once you select the guideline you want to use, click Begin Medical Review

InterQual Process cont.

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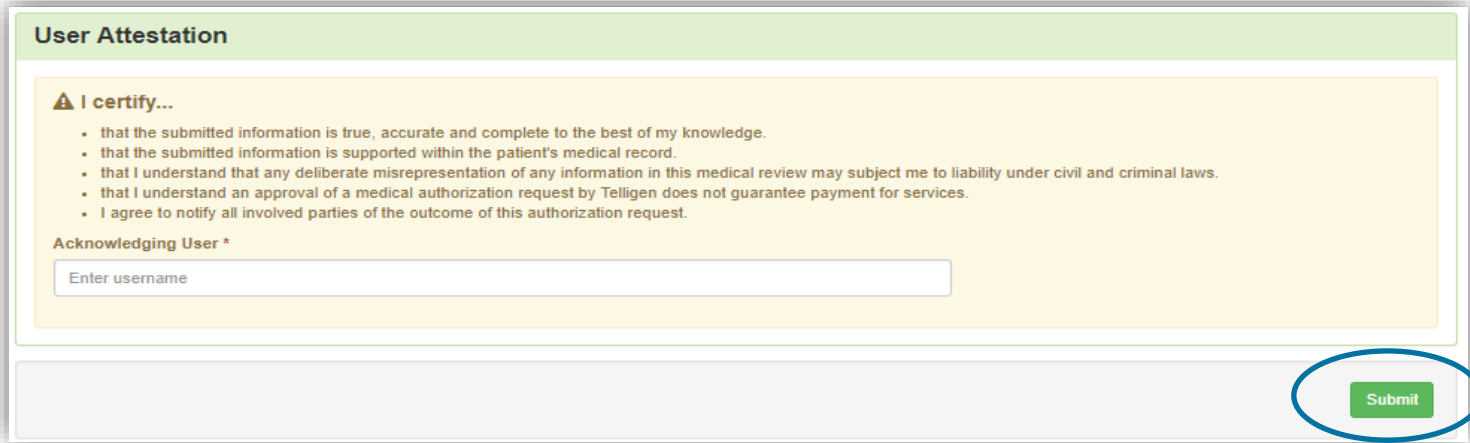
Attestation

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

User Attestation

⚠ **I certify...**
- that the submitted information is true, accurate and complete to the best of my knowledge.
- that the submitted information is supported within the patient's medical record.
- that I understand that any deliberate misrepresentation of any information in this medical review may subject me to liability under civil and criminal laws.
- that I understand an approval of a medical authorization request by Telligen does not guarantee payment for services.
- I agree to notify all involved parties of the outcome of this authorization request.

Acknowledging User *

[Enter username]

[Submit]

- Click the Submit button to send the review to Telligen
- If any information is missing, an error will indicate what is missing
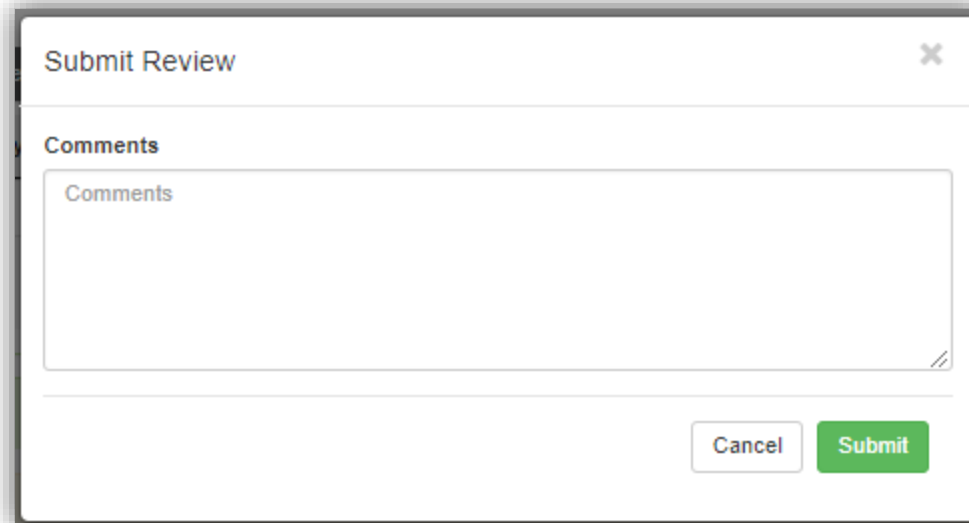
❗ **Error saving your Request**

There was an error with the following panel(s):
- Documentation - You must have one or more documents

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.
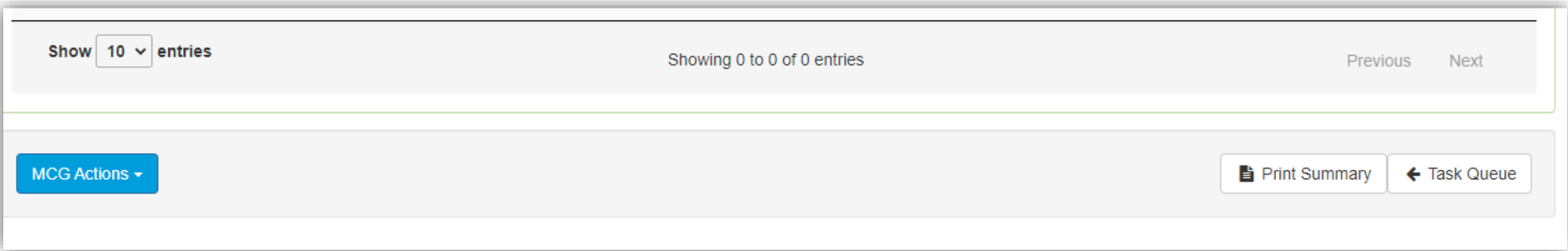- **This is not required to complete the review**.

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.

Show [10 ▾] entries   Showing 0 to 0 of 0 entries   Previous   Next

[MCG Actions ▾]   [🖹 Print Summary] [← Task Queue]

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
2	N/A	5

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.
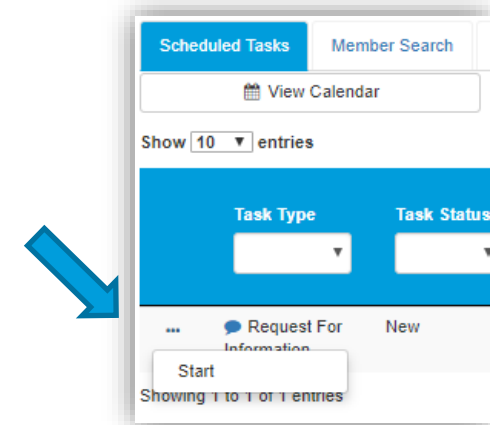
Request for Information

- 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.
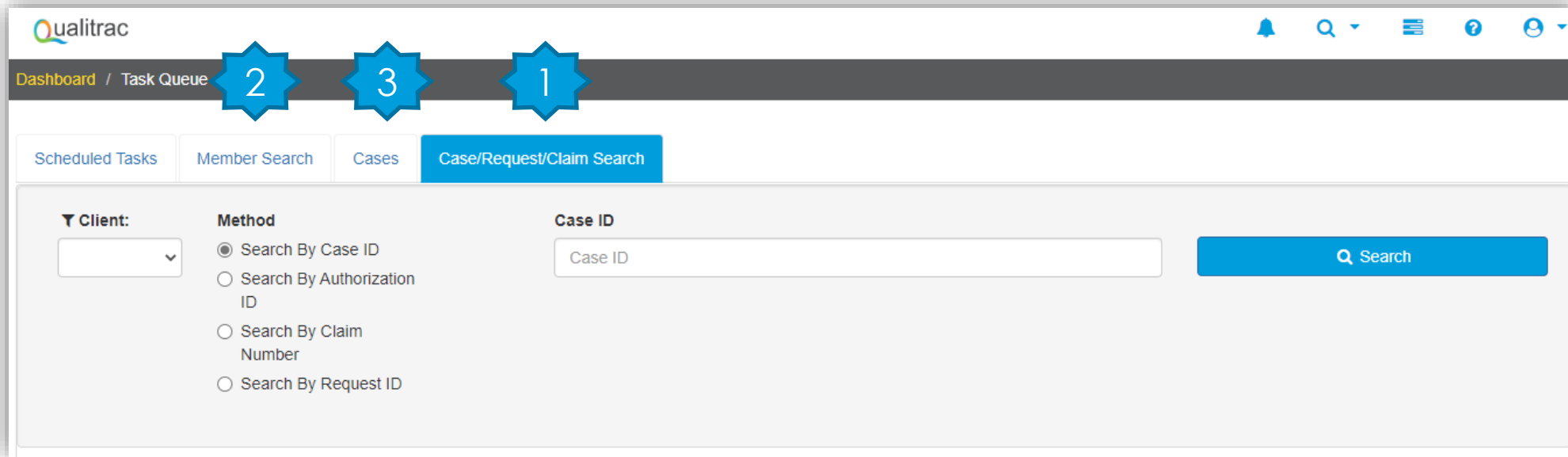
Finding the Determination

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.

Utilization Management   View Requests   + Add

Hiding canceled requests.   Show

Non-Emergency Outpatient Advanced Imaging (36826)   Treating Provider: JACKSON, ALLEN

View Outcome

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

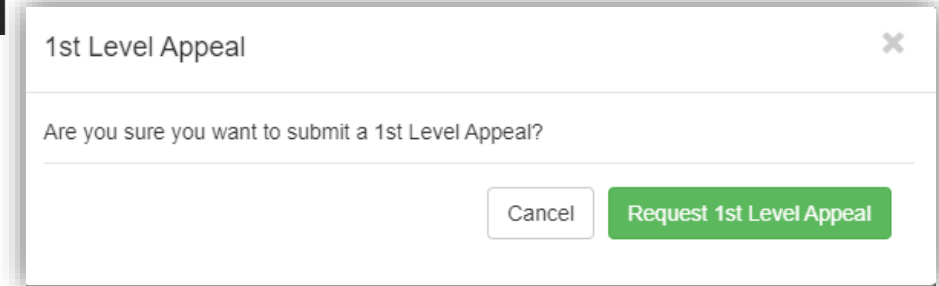# Submitting a Reconsideration (1st Level Appeal)

- 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**
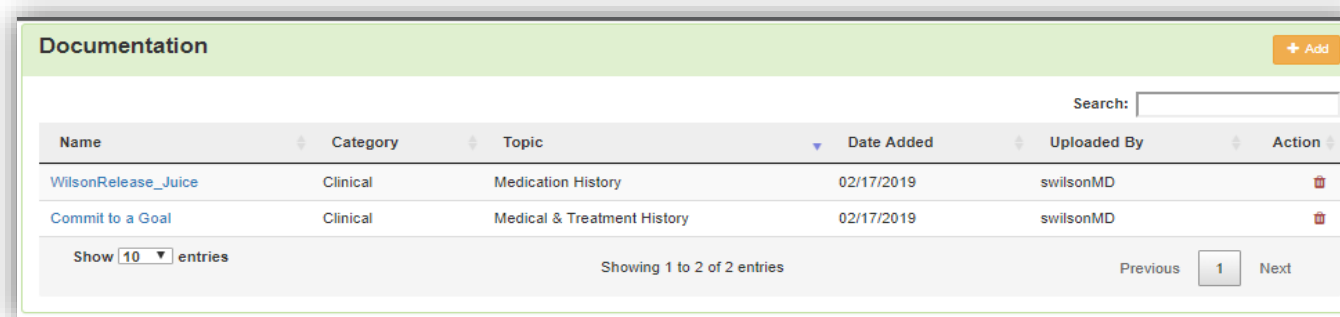 - You will still be able to delete the request later

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

Reconsideration (1ˢᵗ Level Appeal) cont.

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

User Attestation

⚠ **I certify...**
- that the submitted information is true, accurate and complete to the best of my knowledge.
- that the submitted information is supported within the patient's medical record.
- that I understand that any deliberate misrepresentation of any information in this medical review may subject me to liability under civil and criminal laws.
- that I understand an approval of a medical authorization request by Telligen does not guarantee payment for services.
- I agree to notify all involved parties of the outcome of this authorization request.

Acknowledging User *

Enter username

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

Non-Emergency Outpatient Advanced Imaging (36826)   Treating Provider: JACKSON, ALLEN

Show 10 ⌄ entries   Search:

Module	Timing	Status	Date Request Received	Case Completed	Outcome	Action
Medical Necessity	Prospective - 1st Level Appeal	Request Has Been Submitted	12/28/2023 12:28 pm		Pending	...

> The system will display your appeal

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.
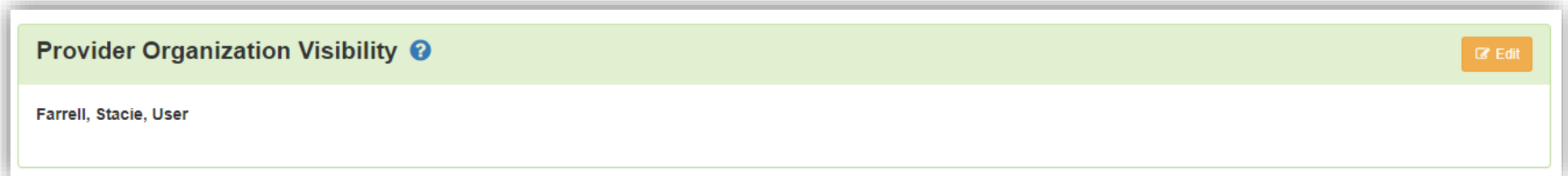
E-mail Notifications

- 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.

Contact Us

Education Manager – Primary Point of Contact   **Program Manager**

Katrina Merriwether   AJae Devine

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
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Questions