Frequently Asked Questions (FAQ)

Dental Authorization

Can we add to or change a request once the service has been performed?

No. A new request must be submitted. The new request should only include the services that need to be added.

What documentation is required for submitting a dental claim for ASC procedures?

For ambulatory surgeries, include:

- H&P (History & Physical)
- Physical examination
- Any available labs or x-rays
- Physician's plan of treatment, including signed orders

Should orthodontic prior approvals be submitted prospectively?

Yes. All orthodontic requests, including initial D8080 and continuation D8670, should be submitted prospectively. The service dates should reflect the full treatment period, typically 2-3 years.

What is the turnaround time for processing ASC dental claims?

- Prospective dental reviews: 6 business days
- Retrospective dental reviews: 10 business days

Does Telligen require an Orthodontia checklist for PA requests?

Yes. The Orthodontia PA form can be found in the document library: Orthodontia PA Form

Can additional services be added to an existing approved request?

No. Additional services cannot be added to an existing approved request. A new request must be submitted. However, a change request form is available for date modifications, quantity changes, or updating information: 2025 Change Request Form

Do specific codes require additional documentation?

Codes 41899, 00170, and G0330 **no longer require** prior authorization from dental providers. Please do not submit requests for these codes.

Is there an easier way to enter full-mouth extractions?

Currently, extractions must be entered individually (e.g., 25 extractions require 25 entries using code D7210). Each entry must specify the tooth number associated with the extraction.

How long are approvals valid?

Approval remains valid for the date range specified in the request.

Are retrospective authorizations allowed for nitrous or sedation?

- Retro authorizations for nitrous are allowed within 5 business days after treatment.
- Retro authorizations for sedation are not allowed.

What is the place of service for dental services in outpatient hospital settings?

ASC providers billing with taxonomy 261QA1903X are considered ASCs. No prior authorization is required for ASC dental (CDT) codes, unless a specific code requires prior authorization.

How many points are required for the scoring tool in outpatient facility approval?

A minimum of 20 points is required for consideration.

How can providers verify a beneficiary's eligibility?

Providers can verify eligibility through the MESA Provider Portal by logging in, selecting the 'Eligibility' tab, and searching by Member ID, Social Security Number, Date of Birth, or Full Name. Ensure that coverage is Fee-for-Service for the requested Date of Service.

What is the timeframe for responding to a Request for Information (RFI)?

Providers have 10 business days to respond to an RFI. Failure to respond within this timeframe may result in denial.

What are the review processing timeframes?

- Prospective Reviews: 6 business days
- Retrospective Reviews: 10 business days
- Emergency Treatment Retro Authorizations: Must be submitted within 5 calendar days
- D1110 Code Submission: Must be submitted within 5 calendar days

What are the appeal options and timeframes?

- Reconsideration (1st Level Appeal): Must be submitted within 30 calendar days from the outcome letter.
- Peer-to-Peer (P2P) Review: Providers can request a discussion with a Telligen physician.
- Administrative Appeal: If dissatisfied with the outcome, an appeal can be submitted to the Mississippi Division of Medicaid.

What documentation is required for a prior authorization request?

- Date of service
- History from the initial visit
- Chief complaint for each visit
- Tests, radiographs, and results (must include beneficiary's name, date, and be legible)
- Diagnosis and treatment plan (including prescriptions)
- Signature or initials of the dentist for each visit
- Orthodontic criteria checklist, if applicable
- Dental scoring tool (minimum score of 20 for consideration)

What should providers do if a prior authorization request is denied?

- Review the denial reason in the portal and determine if additional documentation is needed.
- If the denial was due to missing information, submit a 'Request for Information (RFI)' response within 10 business days.
- If necessary, file a 'Reconsideration Appeal' within 30 calendar days.

© Telligen 2024

Can providers update the service dates for an approved request?

Yes, a 'Change Request Form' can be submitted for date modifications, quantity adjustments, or corrections to provider information.

What happens if an authorization request is submitted incorrectly?

Providers should not submit a new review. Instead, they should follow the 'Request for Information (RFI)' process to update missing details.

How can providers contact Telligen for additional support?

- Email: msmedicaidum@telligen.com
- Call Center: 855-625-7709
- Fax: 800-524-5710

How far in advance can providers submit a prospective review request?

There is no specific window for submitting a prospective review. Providers may submit requests far in advance to ensure authorization is in place before services are rendered.

What happens if eligibility changes after submitting a request?

Providers should verify eligibility using the MESA Provider Portal before submitting a request. Coverage can change daily, so it is important to confirm that the beneficiary has Fee-for-Service coverage at the time of request submission.

How should providers ensure they are selecting the correct provider in the system?

When searching for a treating physician or facility, providers should use the most current Medicaid Provider ID instead of the NPI number to avoid incorrect selections. Gainwell reissued new provider ID numbers, so it is important to verify provider details before submitting a request.

What documentation is required for continuation of care requests?

Providers requesting continuation of care must submit clinical information from the original request along with a copy of the approved authorization from the previous UM/QIO. If the lifetime orthodontia limit has been reached, the provider must include detailed justification for continued treatment.

What happens if the uploaded documentation is not legible?

All documentation must be legible and unaltered. Documents that have been faxed multiple times may become distorted. If the submitted documents are not readable, a Request for Information (RFI) will be issued, requiring the provider to resubmit clear documentation.

What are the requirements for submitting documentation in the InterQual process?

InterQual is integrated into Qualitrac, and all required documentation, including diagnosis and procedure codes, must be entered accurately. If there are no applicable clinical guidelines, providers should check the 'No Guidelines Applicable' box and provide a detailed explanation in the comment section.

© Telligen 2024

What should providers do if they receive a Request for Information (RFI)?

Providers should not start a new review. Instead, they should log into Qualitrac, locate the case, and attach the additional requested documentation under the existing request. Responses to RFIs must be submitted within 10 business days to avoid denial of the request.

How should providers submit a reconsideration appeal?

A reconsideration appeal can be submitted through the Qualitrac platform within 30 calendar days of the outcome letter. Providers should include additional supporting documentation that was not part of the original submission.

How can providers request a Peer-to-Peer (P2P) review?

A P2P review can be requested through the Provider Help Desk via email or phone. Providers must provide the case ID number, the requesting physician's name, available time slots, and contact information for scheduling.

What is the process for submitting an administrative appeal?

If reconsideration and P2P reviews do not resolve the issue, providers may submit an administrative appeal in writing to the Mississippi Division of Medicaid at:

Office of Appeals
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

What happens if a provider fails to respond to an RFI within 10 business days?

If a provider does not respond to an RFI within the 10-day timeframe, the system will automatically deny the request, requiring the provider to start the process over.

Can additional personnel be given access to Qualitrac reviews?

Yes. When submitting a review, providers can add additional personnel under the 'Provider Visibility' section in Qualitrac to ensure they receive notifications and can complete tasks related to the review.

How does using the correct Medicaid Provider ID affect claim approval?

Using the correct Medicaid Provider ID is crucial to avoiding claim denials. Prior authorization (PA) requests must be submitted with the correct Medicaid Provider ID, as the PA is linked to the provider's ID for reimbursement purposes.

© Telligen 2024