Mississippi Provider Qualitrac Q& A Jan 2025

How do providers receive login information for the Qualitrac provider portal?

Providers who registered for the Qualitrac provider portal will receive their login credentials within 5-7 business days. If login details are not received, contact Provider Customer Service at 1-855-625-7709.

What Medicaid programs does Telligen process prior authorization (PA) requests for?

Telligen processes new Fee-for-Service (FFS) Medicaid prior authorization requests only. MississippiCAN (MSCAN) and CHIP PA requests continue to be handled by their respective coordinated care organizations.

How can providers verify eligibility before submitting an authorization request?

Providers must check the MESA portal to confirm Medicaid eligibility before submitting a PA request. Eligibility can change daily, so verification is necessary to avoid claim denials.

How are authorization requests classified by timing?

- **Prospective Review**: For services that have not yet been provided (future-dated requests).
- **Concurrent Review**: The first review of a service already in progress.
- **Retrospective Review**: For services that have already been provided but need authorization due to eligibility updates.

What are the processing timeframes for different authorization types?

- **Prospective Reviews**: 6 business days
- **Concurrent Reviews**: 6 business days
- **Retrospective Reviews**: 10 business days
- Emergency Treatment Retro Authorizations: Must be submitted within 5 calendar days.

What are the Different Types of Authorization Reviews?

- Autism Spectrum Disorder Services
- Cardiac Rehabilitation Services
- Community Mental Health (Outpatient)
- Dental services
- Diabetes Self-Management Training
- Disabled Children Living at Home (DCLH)
- DME
- Expanded EPSDT
- Expanded Home Health Services
- Hearing Services
- Hospice Services
- Hospital Outpatient Mental Health
- Inpatient Health
- Inpatient Psych
- Level of Care
- Molecular (Genetics) 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
- Surgical Procedures
- Therapy Services
- Vision Services

What happens if a provider selects the incorrect physician or facility when submitting a request?

If incorrect provider information is entered, a Request for Information (RFI) will be issued, requiring a correction. To avoid this, providers should search using the Medicaid Provider ID number instead of the NPI to ensure accuracy.

What documentation is required for a prior authorization request?

- Date of service
- History and physical examination
- Physician orders and medication list
- Treatment plan and evaluations
- Progress notes from the last 6 months
- Clinical rationale for requested services

What happens if an RFI (Request for Information) is not responded to?

If a provider does not respond to an RFI within 10 business days, the case will be automatically denied. Providers should check the Qualitrac portal regularly for RFI notifications.

Can multiple services be requested under one authorization?

Currently, certain services such as PT, OT, and ST must be submitted separately. Telligen is working on streamlining this process for future improvements.

How far in advance can providers submit a prior authorization request?

Providers can submit a prospective PA request up to one month in advance of the anticipated start date of services.

What is the process for requesting a Peer-to-Peer (P2P) review?

Providers must call 1-855-625-7709 and provide:
- Case ID or Member ID
- Requesting physician's name and contact information
- Available time slots

Requests should be made within 30 days of a reconsideration denial.

What are Telligen's operating hours for provider support?

Telligen operates Monday - Friday, 8:00 AM - 5:00 PM CST.

What should providers do if a PA request was submitted late?

Late PA requests are only approved for medical emergencies or if the provider lacked necessary information at the time of submission. Providers must submit full documentation supporting medical necessity for retrospective reviews.

What is the maximum timeframe for submitting a retrospective review?

Retrospective reviews must be submitted within 90 days of the Medicaid eligibility determination date in accordance with Mississippi Medicaid policy.

How should providers submit a Change Request for an existing authorization?

To update an existing authorization (e.g., changing service dates or provider details), providers should submit a Change Request Form via Qualitrac. The form can be found in the Document Library on the Telligen website.

Who should providers contact for issues with the Qualitrac portal?

- Technical Support & Portal Access: qtregistration@telligen.com | 1-833-610-1057
- General Prior Authorization Questions: msmedicaidum@telligen.com | 1-855-625-7709
- Fax Number for Case Submissions: 1-800-524-5710

How long do providers have to submit additional documentation for a case?

Providers have 10 business days to submit additional documentation if requested via an RFI. Failure to respond within this timeframe will result in case denial.

If a member changes insurance and then returns to Medicaid, is the prior authorization still valid?

If a member transitions from MississippiCAN to FFS Medicaid, providers must submit a new PA request and include the MSCAN approval letter. Telligen will review and accept the previous authorization if medically necessary for continuity of care.

What is the role of InterQual in the PA review process?

InterQual is integrated into Qualitrac and provides clinical guidelines for determining medical necessity. Providers must complete the InterQual process during submission. If a diagnosis does not match a subset, providers should manually enter the correct diagnosis and justification.

How do providers submit a care management referral for high-risk beneficiaries?

Providers can refer Medicaid beneficiaries with complex health needs (e.g., HIV/AIDS, hemophilia, postpartum care) to Telligen's Care Management team. Referrals can be faxed to 1-800-520-6564 using the Care Management Referral Form available on the Telligen website.

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.

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.

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.